VOL. 11 JULY, 1937 No. 3

THE PSYCHIATRIC QUARTERLY

RICHARD H. HUTCHINGS, M. D., Editor

CLARENCE O. CHENEY, M. D., Associate Editor

PUBLISHED BY AUTHORITY OF THE
NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE
DR. FREDERICK W. PARSONS, *Commissioner*

The Psychiatric Quarterly, formerly the State Hospital Quarterly, is the official organ of the New York State Department of Mental Hygiene.

Volumes begin with the January number. Annual subscription rate, $2.00.

Editorial communications, books for review and exchanges should be address to the editor, Dr. Richard H. Hutchings, Utica State Hospital, Utica, N. Y.

Business communications, remittances and subscriptions should be addressed to the State Hospitals Press, Utica, N. Y.

Entered as second-class matter April 17, 1917, at the postoffice at Utica, N. Y., under the Act of March 3, 1879.

TABLE OF CONTENTS

SCHIZOPHRENIC THOUGHT

With Case Report

BY BENJAMIN POLLACK, M. D.,
SENIOR ASSISTANT PHYSICIAN, ROCHESTER STATE HOSPITAL

The general picture of schizophrenia or dementia præcox is fairly well known and is fully described in textbooks of psychiatry. The mechanisms of this disorder however are not so well understood, especially by those not actively engaged in psychiatry.

It has been estimated that two-thirds of cases have their beginning before puberty, and it is possible that in the majority of patients accurate anamneses would indicate that evidences of this disorder were present long before the family or friends actually recognized them. Farrar has emphasized this by stating "it may be a legitimate question whether in any præcox case the early history could be set down as negative if complete data were at hand."

The symptomatology of this disorder is naturally varied because it is recognized that this group is composed of a number of loosely related subgroups held together by a few common characteristics. The disturbance of affect, characterized by apathy, indifference or undue contentment is possibly the most outstanding of the variants. Associated with this is a dreamy phantastic life which causes a lack of touch with reality and a consequent lack of appreciation of everyday problems so that any concentrated attention to a situation becomes difficult, and usually results in a mechanical adaptation. Thus ideas which normally might cause a feeling of remorse are expressed with indifference or even in a happy or cheerful mood. This is merely an outward sign of a widespread disintegration of the patient's personality well expressed by the term intrapsychic ataxia. He may lose pride in his personal appearance to the point of actual untidiness. The important concept to be recognized is that to this patient the dream world is the real world while the real world to him is a vague shadowy periphery or often an actually unreal world. As a result, the events of the real world are of trifling importance to the patient as they appear to him imaginary events. In his own world, gratification and success are

easy to attain and thus his ego is satisfied, causing increasing tendency to substitute this mode of reaction and less desire to face the conflicts of actual reality where achievements are not so certain and satisfaction is not so frequent. Any interference from the outside world is looked upon as unjustified; the patient feels that the world revolves about him, since his dream world always has him portrayed as the central and most important figure. Increasingly, intrusion is looked upon as aimed to dethrone him from his pinnacle of greatness. From this arise ideas of reference, hallucinations and delusions in an attempt to guard his phantasy world. Thus are built up various delusional systems of either a vague or elaborately systematized type.

This concept of the schizophrenic state with its introversion, dominance by numerous delusions and regression to an archaic or infantile type of expression, is the key to the understanding of the schizophrenics. However it must be remembered that rarely is the disintegration so complete that remnants of the old personality cannot be perceived. Primitive type of thought is frequently marked with references to ideas of rebirth, of control by supernatural means or by modern inventions such as radio, electricity or magnetism. Religious and sexual delusions play an important part and frequently are associated with the assumption of grandiose rôles such as that of a king, God or Jesus Christ. Ideas of reference are extremely common and serve as defense mechanisms whereby their own deficiencies are transferred to their environment or individuals in their environment sometimes because of their public prominence. A study of the writings of Freud or Jung is very enlightening, showing as they do the tremendous influence the sexual life of the individual plays in his social adjustment. This factor becomes increasingly more evident as more cases are seen. Difficulties of adjustment through the narcissistic, homosexual and heterosexual phases of development are seen as the greatest sources of the patient's delusions, although often more or less obscured by disguise. Retrogression to various stages of psychosexual development are exceedingly common. Impairment of intelligence is variable and may be rapid, as in the hebephrenic type, or slow, as in the paranoid type.

The following case is presented in detail because of the unusual ability of the patient to sense the internal struggles taking place. It demonstrates in a clear fashion the struggles of a 22-year-old girl beginning at the age of six with difficulties of adjustment indicating even at that age the knowledge that her love for her father was not only that of a daughter but also flavored with a sexual component which she at first attempted to overcome by quarrels with her father and increased attention to her mother. As she states "I vowed to destroy myself and have continued ever since." She has become a typical dreamer with short periods when she attempted to adjust and then more prolonged intervals when she plunged deeply into her imaginary and more satisfying world. When away from home she has fallen in love only with older married men who to her represented father surrogates. In this way she escaped her former sense of guilt and at the same time, partly gave expression to her sexual cravings.

The history and findings of this patient are briefly given below. Miss A—— F——, No. 17372, age 22, unmarried, of English descent, was admitted on a regular commiment after having voluntarily admitted herself to the psychiatric division of one of the leading general hospitals of Rochester.

The *family history* is interesting; the maternal grandfather died of paralysis; the rest of the grandparents apparently died of natural causes. According to the mother, the father of our patient is very nervous, domineering, stingy and difficult to get along with. He sells Bibles and apparently barely makes a living. Our patient describes him as religious, shy, nervous, ignorant and inclined to tantrums. While our patient has always quarreled with him, she, nevertheless, has shown considerable concern regarding him. He has made the family life difficult because of his stubbornness. They live at present in the business section of the city in a flat without electricity or other modern comforts. There is no home life as he insists on going to bed for his health at 8 o'clock every evening. Apparently any noises upset him.

The mother is described as of a more stable type. She was at one time in charge of a large mission in New York City and was also governess in a family there. She is described as religious, seclu-

sive, she has no close friends, nor has she any hobbies except her religion. There is one sister, 20 years of age, who is described as decidedly the opposite type of our patient. It is interesting to note that even at the age of two, our patient screamed and showed marked tantrums when her baby sister was brought before her. It is stated that it was a common occurrence to see this sister with her face scratched by our patient, who would brazenly admit the fact but would give no reason. This sister, like our patient, attended college and is at present a student. The sister is a typical extravert and has made numerous friends and social contacts. She is engaged to a student in the medical course at a university. Our patient has apparently never been jealous of her sister, on the contrary has always been happy to receive a visit from her sister's boy friend. This sister states that she has always tried to make our patient attempt to enlarge her circle of friends and to attend various social functions. Most of her attempts, however, have met with only meager success.

The *personal history* of the patient reveals that she was born in Rochester 22 years ago. Her early physical development was apparently normal and she never had any serious illness. Menses began at 14. She began grammar school at six years of age and advanced rapidly. She graduated from high school in 1932 with honors, having been elected to membership in the National Honor Society. Her I. Q. at this time was given as 134. In September, 1932, she entered college. Her record there was erratic from the start although she managed to complete three years with fairly good marks, at which time she had a "nervous breakdown." She has apparently always been of an "artistic makeup" and is able to draw and paint very well. She showed marked interest in chemistry and spent a great deal of time bent over test tubes and vials. In spite of her preference in this field she opposed her father when he suggested that she go to the Mechanic's Institute rather than to college. At college, although her work was of good grade, she became involved in some difficulty because of her attachment to a teacher. This will be dealt with in greater detail later on. In addition to this difficulty, for no apparent reason, she stole some money from a fellow student. She later confessed to this but would

give no reason for her actions. It was felt at the time that it was an attempt by herself to attract attention as heretofore she had been a very seclusive student who had not entered at all into any activities of the college. Apparently the patient has never made good social adjustment. She has always been seclusive and inclined to curl up in a chair and daydream. She was constantly antagonistic towards her father but at the same time maintained her preference for him, remarking, "Just because you fight with a person doesn't mean that you hate him."

Psychosexual history shows a very poor adaptation. She has never been known to have a "fellow" and rarely mingled with other girls of her age. She has frequently become attracted to older, married men, especially those in authority, and has built up various phantasies. At times she developed attachment to females. This was especially marked in regard to a female psychologist, a Dr. B——, who has had frequent contacts with our patient during the last 10 years. There is also a history of an attachment to a girl of her own age. Our patient at this time realized the sexual nature of her feelings for this friend. It is interesting to note that this girl later became a patient in a large mental hospital. Our patient has never had any heterosexual relations. However, she has indulged in mutual masturbation with males and has also masturbated herself. During one of these explorations she ruptured her hymen. In this hospital she has entertained frankly sexual feelings towards one of the physicians and one of the nurses and has wavered in her choice of one or the other. She claims she has strong heterosexual feelings but does not know whether they are stronger than her homosexual feelings. She remarks that she first became aware of her heterosexual feelings when they became directed towards her father.

Her *occupational history* is moderately revealing. Following her so-called "nervous breakdown" she obtained a position as a stenographer in the Big Sister's Council. Later on she obtained a position as a housekeeper in a private home at five dollars a week. Although she had never done housework she appeared to enjoy this for the next six weeks, although it was a large and rather difficult home to look after. Later she gave up the position but claimed

that she had enjoyed the training, even though her hands were badly chapped and cracked. Following this position she went to the Y. W. C. A. and roomed there. She then obtained a position as stenographer at the E—— K—— Company and worked there for almost a year. She rarely visited her home. She seemed to be making an attempt to adjust herself and became much more active socially than at any time previous. She bought good clothes and associated with other girls, even occasionally going to parties. However, it was obvious that the adjustment was only on the exterior, as will be seen later.

The present illness is essentially a continuation of her difficulties throughout the last 10 years. Apparently she began to suffer from auditory hallucinations to such an extent that while at work she could not distinguish real from imaginary people and as a result had difficulty in taking dictation. At this time she again consulted the female psychologist, who told her that if she couldn't adjust herself "then suicide was a perfectly rational procedure." The patient apparently worried considerably about this. She spoke to the forelady concerning her difficulties and was referred to the company physician who could find nothing wrong with her physically. She then asked for an extended vacation, which was granted. The following day she applied for voluntary examination at a general hospital and was then admitted to the Rochester State Hospital. Her mental examination is illuminating, especially the interpretation and symbolism that she has built up. At first she refused to discuss her difficulties and appeared rather surly, antagonistic and suspicious even though she cooperated well with the admission routine. She was neat and tidy and appeared to have a good personality. The following day she was noted by the nurses as being seclusive, sitting most of the time in a chair with her legs curled up, staring off into space and apparently oblivious to her surroundings. She could be heard carrying on a conversation to herself in an undertone. At times, however, she would mingle with others for short periods and was an efficient ward worker. After her confidence was won the patient appeared to be spontaneously overproductive, she spoke freely and in great detail. She refused to allow direction of her stream of thought and insisted after a

while on giving a spontaneous account of her troubles in her own fashion. She showed good choice of words and evidence of some knowledge of psychological and psychiatric terms, the result of extensive experience with trained workers in these fields. Her stream of thought was always coherent and relevant but not always logical. She frequently smiled apologetically and hesitated before replying and then spoke in a rather pleading or beseeching manner. Her story appeared to have been rehearsed frequently. She showed good powers of description and as a result of this her case is of marked interest.

Her emotional reaction throughout this period was rather superficial and showed little fluctuation. There was no embarrassment at the recitation of even her most intimate difficulties. She indicated at intervals that she realized she had been abnormal and repeated her intention to "be normal and rejoin the world." Emotionally the patient is self-centered, markedly introspective, reserved, antagonistic and, in spite of her expressed desires, obviously indifferent. At times she wears a silly smile which would indicate that she apparently is actually enjoying the situation. Although at times she is somewhat sociable she is, for the most part, seclusive and self-absorbed. There have been periods when she showed some catatonic behavior and some confused periods during which she would become obviously silly.

Her trend merits attention. It comprises a rather unusual analytical study by the patient of her life, beginning at the age of six. It indicates that she has always been a rather introspective, self-absorbed, seclusive individual who has lost to a great extent her contacts with the outside and also has been content to live her life by herself with very few friends. There have been a few attachments to individuals of both sexes. It indicates that at an early age she began to realize the influence of her libido as a conscious factor and also the struggles of her ego, super-ego, and ideal in the development of her libidinous instincts. There has been a very marked and obvious psychosexual maladjustment. Apparently she has never actually reached an adult level, although she claims that at the present time there are strong heterosexual urges present. Probably her libidinous development ended more or less at

the homosexual level. There have been marked homosexual urges but apparently no such practices. There are also fairly marked narcissistic and onanistic tendencies. She has made strong feminine attachments, has felt sexually inclined towards these individuals, but has realized the unconventionality of her emotional state and has struggled against it. She has, however, indulged in onanistic practices, especially at the age of 14, for a period of a year, and since then only infrequently and not quite so intensely. In addition there have also been periods during which she practiced mutual masturbation with young males. There is also evidence of a marked electra complex which is expressed in a feeling that her father is the sufferer in the family and a rather marked dislike for her mother. This has also been further expressed by attachments to older men, most of which had a marked sexual significance. She has on a few occasions gone out with younger men but has not felt much attraction for, nor interest in them. She has had no heterosexual relations. She admits a good deal of sexual curiosity from the age of 13 years up. During one of her explorations she ruptured her hymen. On about a half dozen occasions, she states, she allowed young males to masturbate her, more or less out of curiosity. She denies that she has ever had an orgasm. She says she does not desire to marry at the present time and until she conquers what she realizes are abnormal instincts.

She gives a well-constructed story of her sexual development beginning at the age of six and colors it with other events, most of which she recognizes are frankly sexual and others which she apparently does not realize are sexually significant. There have been several periods during which she believed she was hallucinated. At all times the voice was female and merely uttered her name. The first period of hallucinations occurred at about the age of six, then apparently for short periods at 10, 13 and finally one at 22. These apparently were not very emphatic and more or less transient in nature. In her development she has obviously recognized a marked splitting in her personality and has designated the separated entity her "psychic personality or energy." Her first recognition of the schism appeared at the age of 10 years. At this time she believed that her personality or psychic energy suddenly was pro-

jected out of her bosom and remained directly in front of her. She described how at the ages of 10 and 13 she was able to go into self-induced trances during which she could project another's personality or her own personality and actually see what they were thinking and also understand or realize their desires or inclinations. During this state she claims she is not unconscious but unable to talk perfectly, although she knows the words. These self-induced trances persisted up to six months ago. At one time she harbored delusions of persecution of a rather vague type but these have disappeared. At that time it was her belief, for a short time, that a man was pursuing her with the intent to stab her in the back. She has never entertained the belief that electricity or radio were being used to influence her actions. At present she believes that she was hypnotized by a female psychologist and has never been able to throw off this influence. There are a host of symbolic sexual references indicating a strongly homosexual trend with weak heterosexual tendencies as well as some narcissistic, sadistic, onanistic and autoerotic inclinations..

Her story follows:

I had a nervous breakdown when I was in college. I had been fighting with myself most of my life and finally gave up. It began in junior high school. I was told to see the school psychologist. I had made good grades in grammar school and in the eighth grade became restless and lost my interest in school. I began to cut classes. The school psychologist, Dr. ——, a woman, became interested in me. She saw me very often and tested out my reaction to various situations. I have seen her off and on for ten years. These situations shouldn't have persisted and were too much for me. I did not meet them properly then and never got over them. They were reactions to people, for instance, women teachers, ones that were annoyed at me. I always took the attitude of liking them instead of getting mad. It was a religious idea of turning the cheek. Then they (the psychologists), tried to work the same system on the male teachers.

It was the same as if I was having intercourse, not on a physical basis but on a personality basis. I was thirteen and didn't know what it was all about. The male teachers were mad at me. It was an artificial situation and we would want to see if it was right. You see, you know I can see people inside. It happened first at six, it was my mother who began it. She was worried and couldn't get my point of view. She then came over

to me, I could see something inside of her coming to my level, it was not physical, it was energy. My mother laughed when I told her I saw it. I thought that this was what a person's soul was. I never, of course, believed that afterwards when I began to realize what it was about. The next time it happened again at ten. My mother, as you know, was very religious. She believes in being spiritual, asthetic and a part of the world and therefore does not associate with people. You know, people get queer that way. She once had a mission in New York City and tried to bring us up very thoroughly emphasizing me more than my sister because she must have liked me more or else because I was the oldest. I got the benefit of her religion. My sister and I used to quarrel a great deal. I was always blaming my mother whether I was right or wrong. At ten my mother said I should like everybody.

I can see myself inside the same as in anybody. I can't describe what it's like. There are no words at my command or, for that matter, in the English dictionary that could adequately give a perfect picture. It's the person's personality and goes up and down. I pulled it out in front and let it stay there. Finally something seemed to come from the sides and begin to hold it, it was just like arms. Dr. —— thought it was a symbol. I always kept it until recently. My mother was very much distressed. She said I could not always like people. I looked and I saw myself in the same pattern. At eleven I was very much upset after a family quarrel. My father and all of us knew he was wrong but he would not give in to me and went over to a corner and began to read a paper. I'd always kissed him before going to sleep. You see, I'm very much fonder of my father than my mother. Towards evening he did not give in and I was not going to kiss him but my mother told me not to mind so I went and kissed him but he did not look up at me. I then went to bed very much angry. You see, I still had to carry on in my situation with him.

In the eighth grade, the trouble was I was growing up. I became restless and did not want to study. You see, my father is poor and I did not have proper clothes. I was interested in my appearance and was bothered to have to go to school that way. I went to see Dr. ——, a psychologist at the high school, about this same "pattern." One day she decided to have the female teachers in the office and discuss my troubles. It was still in the same pattern. I took the attitude of not resenting but liking her. Dr. —— noticed it was unusual and took the situation on herself. That is, she talked to me and tested me out. She decided to experiment with the situation. She tried it on other women teachers and I always tried to like them. I could see their pattern. I have always been alone, I have had no friends

and had lived with my own self. I could go into self-induced hypnotic trances. I sank into a trance, my heart began to beat rapidly. My eyes were wide open and the reaction slowed down. I could perceive but I couldn't react the thing. I saw objects but could not tell what they were. I knew what they were but I could not name them. I lay in the bed and did not want to move. I was conscious, remember. It is in this state that you see a person with person's inside, see other people's thoughts. I tried to get that way at the time. I'd see several things, one right on these person's personalities and corrected them by trial and error. You see, I was nothing but a bungling amateur and had no one to interest them. I always had it to experiment as I could perceive what others couldn't.

Then the male teachers came in, one in particular. I went through the same reaction of liking him and not being annoyed. Although he was urging and not very gallant, I spoke as if I liked him. It didn't make any difference whether he was a man or woman before I did it, but as soon as I spoke I became conscious of my womanhood and acted as if I was flirting. I was only fourteen. He was embarrassed, it was the tone of voice that counted more than what was said. I was annoyed that he should think so. He then accepted the situation that I was not making him fall in love and accepted it. The women, too. Then I'd sit up and move backwards to carry their personality on mine. I did the same with him and he was annoyed, as if he thought I was having intercourse with him. I was also annoyed as I always did this. I projected my personality and then to my surprise, instead of his personality travelling to me, my personality left and travelled to his. I had a feeling as if I had not suppressed it.

I had always projected my personality and their personality fell so that I could see their psychic energy. I'd shoot out my energy and prevent them from falling, I was doing that to him. He was thirty-two and married. He smiled and finally accepted the situation. I was facing him and there was a channel between us. When two people think of the same thing at the same time there is a shudder or a shiver in me. I knew if such a thing happened in a person he would have control of the situation and could do what he wanted. I was afraid as I didn't know him that he would control my personality. I'd always controlled that with women and still wanted to with men. I had a half dozen orgasms, convulsions from head to foot at that time, and then suppressed it in front from my shoulders to the mid-thighs and then let it happen elsewhere. I had a feeling as if I had not suppressed it sufficiently. I felt all right but it came out on my back a dozen times and seems to envelope me. He was interested as he could see that I was supposed to have three or four more, but when it came down to my breast to

rest there I always shot out my energy to carry people. I stopped the orgasm. I shot out my energy. I was working all the time and wanted to change from an emotional to intellectual place, but my personality entered his as with the women and he went through all the motions of intercourse as he was sitting there and gasping and screaming. Dr. —— saw it. I completely suppressed my emotions. Finally, he screamed and said he could stand it no longer. Dr. B. called me and she realized my personality was there inside of him. I pulled my personality back and we were separated. That was the first time my personality had left me. He might have requested it for intercourse. Formerly, with women, their personality had come to me and I sat in positions for intercourse.

He took a handkerchief out and mopped his face. We were then separated and Dr. B. spoke and he got up to leave, and he looked at me and spoke cautiously as if he was afraid of my delicate balance and said, "Thank you, Annabelle." He was thanking me for my personality and intercourse on a spiritual plane. That did not affect me, I was in the same pattern. The shudders I had suppressed were barriers between us to protect me. He then said, "You have given me one of the most perfect moments of my life." He bowed his head and dropped his shoulders as if he were dejected. I felt hurt as he had said "one of the most perfect," not the most perfect moment. It was as if I was supposed to suppress my emotions. He then projected his personality to me. He was confident and sure of himself as if he trusted me. The point was I wasn't there as I was on an intellectual and not an emotional plane now. He gasped to find me away above him. What he saw was what I pulled out of me from inside instead of in front of me as I was in the same pattern. I was afraid he'd lock down and drag me down. He became dejected and looked at me in a soft manner and spoke to me in a kind, soft gentle voice, "Thank you, Annabelle, for not accepting me," and he was a married man. He just lost control of himself temporarily. He thanked me for bringing him to his senses and said, "I hope some day you will find someone worthy of yourself." He remained quietly and spoke very softly. Dr. B. didn't know what to say as there was an atmosphere of reverence and awe. I answered, "I hope I do too, I hope I find him, otherwise I'll be a grandmother before he's born."

Dr. B. was annoyed as she wanted me to stay in this state. She did not follow what had happened. I explained it to her. After he left I went down to an emotional plane and said he had left something. It was part of his personality. I did not know why he had left it as I had been on an intellectual and not emotional plane. In looking backwards I see it is something he had shot over to me, the essence of masculinity, all there was to be

a man. I didn't know what to do with it, I thought of absorbing it, she told me not to. She told me to forget. I pointed to the man and she said it was not there. I admitted it was not corporal, just in my thinking. I still have it and carry it but I never absorbed it, it's very irritating. I still had lots of energy left over on account of the previous suppressions.

She then called in other male teachers. With my mind my personality was immediately projected and without ceremony he put himself in position of intercourse but I didn't want to go through as I had no strength so I took my personality back. The third one was struck with my psychic energy as soon as he entered. He gasped as if cold water had been thrown on him. I did that on every man that came in after that because these men did not want to have anything to do with me, when they went to leave, for instance—when this second man went to leave he could not. When I looked I saw two arms of my personality holding him fast. I laughed and pulled them apart. After a great deal of energy he still could not leave and so from the center of my personality I took a new part and shot it at him. He fell and the arms were released. Dr. B. was very interested.

Then when another came in I was going to strike him with my psychic energy. I didn't want to strike him as he was too sexy. I was afraid he would see me and pull my psychic energy down as he had a terrific attraction for me, so I pulled myself away and he talked to Dr. B. He didn't gasp like the others when he left. She asked me about it, why nothing had happened. I said he was too sexy, I felt it. I could see into his personality which was stronger than mine. In all these situations I was suppressing my emotions and reactions, all these being a part of my personality. When the last man came in I did the same and all of a sudden I came to. I stopped being apathetic as I had been as a child often and actually saw what was happening. I suddenly came to and a part of me that I had out since ten slipped back into place again in front of me and I became an integrated personality, the way I should be.

It made me feel good, normal. I started to expand and get panicky and would react to the situation, scared, not sexual, and just as it happened Dr. B. saw it. She said she didn't want me to become an integrated personality so her personality clamped down on me. I sank down, emotionally, and I have been there ever since. Whatever she did I could not break that again and now live only on an emotional and not intellectual plane and everything has piled up on top of that. It has stifled me. I have never been able to get a reaction to a man since then.

Recently she learned that her mother had never had any "nervous breakdowns" as our patient had always supposed. She was told by her mother that these had really been miscarriages. For some reason this caused a marked change in our patient's behavior. She had also been told that her father was dying from a cardiac condition and this added to the other information caused her to become highly elated. She stated that her previous fondness and sexual attraction towards her father had changed entirely. She no longer regarded him as a quiet, long-abused martyr to his wife's mistreatment. The idealism which had caused her to enshrine her father as the ideal male and acme of sexuality disappeared and was replaced by a marked feeling of elation and almost relief that she had discovered so-called imperfections in him, which she herself would admit. The prospect of throwing off the shackles of paternal attraction at his approaching death caused her for a time to make a greater effort to extrovert her activities and to indulge less and less in day dreams.

Within a few weeks, however, it was noted that she was again returning to her old introspective state to an even greater extent. This was associated with the added belief that she would never get well and with some show of depression or concern which was not deep seated. One gets the impression that she did not actually want to become "normal" again but offered it to appease her superego with the thought that she was trying as hard as she could, "but the forces are too deeply imbedded and are sweeping her in an invincible current to her doom." She has shown periods of catatonic stupor, mutism, projection and the belief that her difficulties are the combination of influences produced by her father and the hypnotic spell put on her by a woman psychologist, which forces her thoughts into an abnormal stream. Sexual aberrations are marked and consist of a struggle between strongly determined homosexual and weaker heterosexual impulses. She shows some concern because a former female roommate with whom she had sexual relations is now in a mental hospital and the psychologist herself has suffered "a nervous breakdown." Her struggle to attain a satisfactory sexual adjustment is vividly described by her.

I did get sidetracked. I got a crush on Dr. B——, a female, then I went to college and got a crush on one of the girls there. She went to a mental hospital later with a nervous breakdown. I have entertained sexual feelings to these women but it quite disgusted me at the time. I asked Dr. B. if she would stop liking me, I could not stop liking her. She laughed and said she would always like me. She has always been a wholesome influence and way above me and I still like her. I don't know, although I haven't kept much contact with her. I only wrote her once when I was in college. I never had relations with a girl but have slept with girls and we both liked it. I never saw her naked and never felt any sexual stimulation at such things. I continued to have some struggles with my personality. I finally got to the point where I could not study. I was on an emotional level all the time suppressing my personality. I was having a terrible time and thought everything was way above me. I spoke to one of the college doctors and in this way managed to transfer my emotion from the girl to him. He was very sexy. That was about a year and a half ago. Then I went home from college and remained in bed for two and a half months. I wouldn't eat anything and I couldn't even wash my hands. All my thoughts irritated me and I couldn't absorb anything. Dr. B. said it was nervousness. My parents couldn't understand it so they left me alone. They thought that all I had to do was take some nerve medicine. I couldn't eat and they didn't feed me. I felt terrible and saw they wouldn't do anything so I got up, got dressed, packed and left home and have been living at the Y. ever since. I went to Dr. B. and she referred me to the Big Sister Council and I worked as a stenographer and later did housework. A sort of comedown after college. It was an awful job but it took my mind off myself. I stood it for seven weeks. I then got several other jobs. I registered all over and finally landed a job as typist at the K——. I felt better then, no one noticed how bad I really was. After six months, that was in April of this year, I told Dr. B. I was going to have another nervous breakdown. I saw Dr. C. five or six times and finally knew I could not stop my fear. I have been fighting since I was thirteen to get where I belong. I knew it was not right. Dr. C. helped me a lot. I gave up my job and left on account of ill health. They said I had done good work. I went to the S—— hospital and told Dr. C. all these experiences and felt better. You know, I have never talked so freely to anyone as to you, not even to Dr. C. He then decided that I wasn't well and sent me here. I haven't been attracted to other girls in the past two years in a sexual way, it was a personality attraction. (This is untrue as she confessed on numerous occasions a marked sexual attraction to a young, attractive nurse who was working on that ward.)

I wasn't attracted to men until I met that man in college. I then returned to Rochester and had a crush on Mr. S., the Baptist minister, and joined his church. I have gone out several times with young fellows but don't like them. I did so to break my inhibition so that things would happen. They had no sexual attraction to me. I've never had intercourse with a man but want to quite strongly. If any men had asked me I would not have allowed them because I would be afraid of pregnancy and also I'd have to know and like them. I began masturbating when I was fourteen or fifteen for a while but I got over it, I did it three or four times a day for hours and then I wouldn't do it again for weeks. It depended on how I felt. After a year I didn't seem to care for it so much. I haven't done it very much in the past eight years, except possibly once or twice a year, but then I used to do it very intensely and would go by myself and do it for hours. The feeling is not so intense now as it used to be and I haven't masturbated recently. I must confess I've even masturbated with men. I used to go to the movies and do it to young males, strangers. This happened about a half a dozen times in my life. They would make the first move and masturbate me and then I'd put my hand inside their trousers and masturbate them. I only went with one of them once and I didn't like him and didn't allow him to do anything to me. Lots of men have offered to have intercourse with me and one promised me an apartment and clothes a short while ago but I had a job. I am actually a virgin although I broke my hymen when I first began to masturbate and I was very frightened. I have always been sexually inclined to father. He does not do it to mother although I don't think he is really aware of that. He is meek and submissive and I think is jealous of mother and her friends.

I have also heard voices several times in the past. Once when I was five or six I was playing and someone called my name but no one was about and I asked mother if she heard it and she said, no. It happened again when I was thirteen and recently when I worked in the E—— K——. There was lots of noise there and I was supposed to carry messages. Sometimes I could hear someone call and couldn't see anyone. Sometimes when they called I thought it was my imagination. I could not distinguish the real from the unreal. I had no visions but I think someone wanted to harm me. I thought there was a man following me around to stab me in the back.

Her progress in the hospital is noteworthy. At times she was quite depressed and usually very seclusive. There were periodic episodes when she became very sociable and would take part in the ward games, play cards or volleyball. She also became a good

worker in the dining room and on the wards. She showed unusual ability in the occupational therapy class, especially in painting, letter work and fine sewing. It was known that she played the piano very well. About two weeks after admission she became upset because she had not had her menstrual period and feared that she might be pregnant although she said that she had not had intercourse. Next day it was noted that she was silly, talkative and laughed in an extremely silly fashion. She then became apathetic and withdrew from other people but still remained tidy and able to look after herself. The following day she refused to keep her clothing on and ran about naked. She was finally induced to put some clothing on and go to the porch with the other patients where she began to masturbate under cover of a book. When one of the male physicians called she refused to talk but remained flat on her abdomen with her eyes closed and a very silly expression on her face.

After two or three days she cleared up entirely from this and became her former self. An attempt was made to discuss reasons for her behavior and her statements are of interest:

I have struggled against myself all my life to do what other people advised, to become more sociable and lose myself among them. I tried with all my strength but have not succeeded in conquering myself. I woke a few days ago and felt very peculiar after having acted very hilarious the night before. I suddenly realized that I was a different person, that I was no longer A—— F—— and therefore do not call me by that name any longer, as I am no more she than you are. For at least ten years, you know, I have realized that I was actually two individuals—one was standing at a distance from me and was such a stranger that I had difficulty in differentiating the two and became quite confused. I could even carry on a conversation with this other individual even though I did not realize what she was to me. The next morning I woke up I was a different person, that I was really A—— F—— plus something else, that I was a greater person because I had incorporated into myself this other individual and had made one entity instead of two. My behavior probably seemed queer but I did this because I did not know how to behave with my new self and did not know how to manage this new individual. I wanted a few days to accustom myself to it and that is the reason I acted so hilarious because it was such a

feelng of relief to find that the other individual was no longer there to confuse my thoughts.

This later interview lasted over an hour and a half and it was difficult to obtain any real ideas from her. She frequently became quite silly and would put her hands over the writer's and close her eyes. She hinted that she had numerous thoughts that she wouldn't disclosure but indicated that she might do so later. Also hinted that she had strong sexual cravings which needed adjustment. It is interesting to note that during the seven months that this case has been studied by the writer, the patient has had marked similar upsets about or during her menstrual period. During some of these she showed very strongly a father surrogate attachment to the writer and at other times appeared to go beyond these boundaries. She still continues to daydream and talk to herself, and then suddenly appears to lose contact with her surroundings entirely. It is noted that this occurred on at least three occasions when a concert was being given on the wards. Although the patient has a knowledge of and appreciates fine music, she was totally unaware of the two-hour program which was being given. At other times during the menstrual period she is content to lie around, curled up in an armchair and stare off into space. Her personality always appears good except when in a disturbed state. She has excellent reasoning and descriptive powers. Apparently her intelligence is excellent as she at all times is an interesting subject to talk to and will discuss her difficulties for hours at a time. More recently it was felt that her emotional reaction was not as adequate as formerly and some indifference to her condition was becoming manifest. She has shown no adjustment whatever even under the most intensive psychotherapy by numerous staff members.

Summary

1. A case of dementia præcox of the paranoid type which has been studied through its entire course of about fifteen years. It demonstrates in an unusually clear manner the various mechanisms and the forces at play in this disorder. It occurs in a girl of 22 of good intelligence (I. Q. 134) and advanced power of description. Apparently no intellectual deterioration has occurred.

2. The influence of psychotherapy is indicated. As is frequently the result, psychotherapy in schizophrenia aggravates the condition by making the patient more acutely aware of the internal conflicts. Lacking the ability to cope with these conflicts, the schizophrenic cannot benefit by this interpretation and goes on to further ruminations in phantasy.

3. It is also interesting that after the above examination was made the patient went into a state of catatonic stupor for a week and became inaccessible for further examination. After this period the mutism disappeared and she became talkative again. She has shown no improvement and has been unable to resolve or sublimate her conflicts although she is acutely aware of their abnormality.

4. As might be expected from the tendency to adopt father surrogates or substitutes she has transferred her emotional objectives to the writer and has frankly expressed her strong sexual inclination to him.

5. In spite of her apparently well-preserved intelligence and personality it is felt that she will deteriorate unless some satisfactory external attachment or sublimation can be achieved.

INFANT FEEDING AND PERSONALITY DISORDERS

*A Study of Early Feeding in Its Relation to Emotional and Digestive Disorders**

BY JOEL HILL, M. D.,
HOUSTON, TEXAS

In recent psychiatric literature[1-2] emphasis has been placed upon the influence of early feeding experiences in the development of personality disorders and there has been much speculation as to their relationship. The belief that additional factual knowledge regarding this relationship might facilitate our understanding of personality disorders has given rise to this investigation.

Some families (See especially cases Nos. 11 and 12) show more than usual interest in the condition of the upper alimentary tract and in the things that pass through it. These families are proud of their good food, and their pleasure in eating may be suggested by their obesity. They are fond of talking or singing. Some members of these families suffer from the so-called nervous digestive disorders and some are alcoholic.

On this account I have paid special attention to the family background of a group of 172 psychiatric patients to determine the degree and kind of interest in the upper alimentary tract. This group was composed of cases in which detailed information regarding early childhood development had already been recorded or was obtained by special investigation. I have made note of events in connection with breast-feeding, the introduction of artificial feeding and weaning, and the early feeding habits and I have tried to ascertain the reaction of the infant, of the mother or of others who were involved. I have attempted to trace the influence of these early experiences in the evolution of subsequent personality maladjustment.

A great many factors enter into the feeding problems of early childhood and consequently the functional nervous disorders of later years. Some of these factors I have illustrated by case material. The mother may be unhappy, oversolicitous or ambivalent in her attitude toward her child; she may prolong the nursing periods

*The material for this paper is from the psychiatric service of the New York Hospital.

because of the pleasure she receives from nursing her child. Her supply of milk may be inadequate or excessive.

Although she may have plenty of milk the mother may feed her baby for an inadequate length of time because her nipples are depressed. Early weaning may be necessary because of mastitis, or cardiac decompensation, or pulmonary tuberculosis. The mother may wean her baby early because nursing interferes too much with her social activities.

The quality of the mother's milk is believed to be impaired by the return of menstruation:

> It is safe to say that the changes in milk accompanying menstruation are not uniform and that in very many cases, none of importance are produced[3]

The impairment may be in part physiologic and it may be due to the mother's pique over the nuisance and discomfort of menstruation. Another pregnancy may cause greater disturbance including early weaning although some women continue to nurse unaware of pregnancy until they notice fetal movements.

Emotional stress undoubtedly may lessen the quantity and impair the quality of the mother's milk.* This stress may be the grief over the death of a beloved one, the anger or anxiety associated with marital disharmony or the hatred of an unwanted child. The prompt cessation of lactation in cases presenting acute catatonic postpartum reactions is probably a manifestation of the painful emotional state of the mother.

Whatever the interference with normal lactation may be the baby may react with inadequate nursing effort or by refusing to nurse. Even though artificial feeding is accepted it appears that the child often senses deprivation and may react later in life with antagonism or an ambivalent attitude toward the mother. Levy[5] has observed that puppies who had been subjected to irregularities of early feeding had different dispositions from those who were

> *. . . It is the nervous condition of the mother more than anything else which determines her success or failure as a nurse.[4]
>
> (The effect of emotional stress on the lactation of other mammals may be observed. The amount of milk secreted by a cow is reduced when she has been chased by a dog or beaten. Recognition of this fact is shown by the advertising of superior milk from contented cows.)

breast-fed the usual time. Not only does maternal breast-feeding appear to be advantageous from a psychological point of view but the mortality of artificially-fed children is considerably higher than that of breast-fed children.

In cases which the writer has included in this study a variety of indications of maladjustment appeared to be associated with the feeding difficulties of early life. Emotional instability was shown by fears, excessive crying and by tantrums. They played excessively with food, ingested foreign substances such as sand or nasal secretions, refused all or certain kinds of food, or they regurgitated it. Finger-sucking or nail-biting was common as was also diarrhea or constipation or incontinence.

In the records of adults who had shown this excessive interest in the function of the upper alimentary tract were many who were troubled with gaseous eructations, vomitting, abdominal pains, constipation or diarrhea. They smoked to excess, were food cranks, epicures or alcoholics. In some cases the symptoms persisted from early childhood and some were free of symptoms until exposed to the stresses of later years, illness appearing after puberty or in adult life. Studies[7, 8] have shown that the gastro-intestinal functions of psychotic patients are practically always disordered.

In this study the group of 172 cases selected from 536 routine admissions to a psychiatric clinic included only those cases in which there were adequate data regarding infant feeding. Some of them were children and none had passed middle age. Patients beyond this age seldom had relatives who could give the desired information.

Period of Breast-Feeding in the 172 Cases

	Breast-feeding adequate (5-12 months)	Breast-feeding excessive (over 12 months)	Breast-feeding inadequate (under 5 months)
Number	72	16	84
Per cent	42	9	49

The accompanying table shows that breast-feeding was adequate in 72 cases, excessive in 16 cases and inadequate in 84 cases. In 35 of the inadequate cases there was no breast-feeding at all. A period of 5 to 12 months of breast-feeding was accepted as adequate although the generally accepted period of six to nine months[9] ap-

pears to be ideal. The child is then able to appreciate other manifestations of the mother's affection and the child's teeth make nursing painful to the mother.

Cases of Inadequate Breast-Feeding

Six cases are presented to call attention to the course of events when breast-feeding is inadequate; a child and two adults with feeding difficulties, digestive disorders, malnutrition and emotional disturbances persisting from early childhood; two adolescents who showed these disorders at puberty; an adult whose early feeding difficulties seemed to be associated with alcoholism in adult life.

Case No. 1 was a boy two years and nine months old. Diagnosis: psychoneurosis. Neurotic vomiting. He was brought to the clinic because of refusal to accept adequate food, vomiting, constipation, malnutrition and angry crying spells.

His parents had planned for two children, but after the arrival of the patient they did not wish the second. His mother often listened to his breathing at night to determine if he was still living. She was nauseated each time he vomited. She was nauseated also by her husband's amorous advances, and when she refused them he was so angry he wished to "smash her head in." He resented the child's requiring so much of his wife's time. The father stopped keeping pictures of the boy after he was a year old, because he was so "skinny and puny."

He was a full-term, seven-pound baby, instrumentally delivered. From the beginning he took food poorly. To keep him from going to sleep while nursing, he was tickled, pinched and slapped. At three weeks a bottle was added to the breast-feeding, and it was noticed that he vomited more frequently following the breast than the bottle-feeding. At two and one-half months, nursing was stopped and semi-solid foods were gradually added to his bottle feedings. He began to suck his fingers and tickle his nose with a blanket at five months. At nine months he talked enough to indicate he was through with his food. When one year old, "he would lie rigid at night and scream his head off." X-rays of the gastrointestinal tract at that age revealed no organic pathology. Consti-

pation, that had been present from birth, was treated by enemas four times a week and at night when he restlessly "pawed the air." At two years the bottle was discarded. Vomiting occurred at any time from immediately after eating to four hours later. It was worse following sneezing, coughing, or excitement. Most of the furniture in the home was soiled with his vomitus. When he vomited at night, his mother washed the sheets at once, even if it was at three in the morning.

When he entered the clinic, he was seven pounds under weight. He did not mingle with the other children and cried for his mother. On being fed he said, "Too much. I have to wait. You eat it. I have to vomit. Too much. All through, all finished. Take it away." He played with his food and ate very little unless urged. Then he had spells of angry crying. He often interrupted his eating to urinate. He required 40 minutes to finish sipping a glass of orange juice. He poured his glass of milk in the wastebasket while the nurse was not looking. He coughed and gagged until he announced, "I have to vomit." He vomited anywhere except in a basin that was kept beside him. He often wet himself, both day and night. He called his faeces his "duty" and took much pride in saying, "It's a big one." When he defecated on the floor he affectionately patted the soiled spot. He screamed angrily when given an oil injection because of obstinate constipation. Intellectual tests indicated he was of normal mental age. During his two months residence in the clinic, he stopped vomiting but sometimes refused to eat, and his weight remained unchanged.

Summary: Mother tense, dissatisfied with her husband, and oversolicitous with the patient. Breast-feeding stopped at two and one-half months. Refusal to eat, vomiting, constipation and angry crying spells developed gradually, the first symptoms appearing during early infancy.

Case No. 2 was a 20-year-old college girl. Diagnosis: dementia præcox, simple type. She came to the clinic because of refusal to eat sufficient food, malnutrition, unsociability, and spells of irritability.

Her present illness was accentuated two years before admission when her sister began a diet for obesity. The patient avoided fat-

tening foods to such a degree that when she came to the clinic she was 30 pounds under her usual weight. She gave no reason for her decreased food intake except that she didn't want to eat. When urged to take food she mumbled to herself or screamed loudly. She took long vigorous walks and refused to be accompanied. Her menses had begun at 12 but were absent for a year before admission to the clinic. When a thorough physical examination, including X-rays of the gastro-intestinal tract, revealed no physical cause for her state of malnutrition, her mother brought her to the clinic.

Her father, an obese man, complained of gaseous eructations and constipation. A paternal aunt suffered from stomach trouble. A sister two years older was not nervous and was somewhat overweight. While the sister was carried, the mother was a little nauseated but happy in spirits, and the sister received nine months of breast-feeding. The patient's conception was accidental and while she was carried her mother vomited and wept most of the time. The mother had discovered that the father was interested in another woman. When the patient was four years old the parents were divorced. Prior to this the mother frequently wept and argued with her husband about the technique of raising the children. The patient was her mother's favorite and received a great deal of oversolicitous care because, as the mother said, "I felt so sorry for her." The father preferred her cheerful, friendly, obese sister, and the patient jealously desired his attention.

At birth she is said to have weighed only three pounds. During her two months of breast-feeding she was "frettish." When bottle-feeding was attempted, she screamed and threw the bottle across the room. She accepted nourishment better from a cup. She was underweight and had frequent attacks of diarrhea. At 10 months solid foods were introduced and she accepted these better than liquids especially when her mother held her on her lap for hours, gently persuading her to eat. When more firm methods were used she hid herself in a closet, screamed, and bit those who came near her. She gained control of her bowel movements at three years, and she no longer wet herself at four. She was a silent child, and until four spoke in an ill-defined language that only her mother could understand.

As an adult she continued undertalkative and occasionally spoke with a lisp. She had few friends of either sex. Her principal interests were saving money, collecting food recipes, and excelling in her college studies. She ate small portions of food and continued underweight. She would not accept milk unless it was served in a lukewarm state. She was the first of the family to arise and the last to go to bed. At times she screamed and walked to her mother while asleep.

On admission to the clinic she wept and tried to get out of a window on the fifth floor. She ate very little, saying she did not care for more. Her father grew sympathetic with her requests to return home and removed her from the clinic after a few days.

Summary: In her family there was much gastro-intestinal difficulty. The marital disharmony and the mother's unhappy spirits were associated with inadequate lactation, and the patient's early irritable weeping spells. Her childish pecularities of casting aside the bottle, accepting nourishment better from a cup and solid foods better than liquids, along with her adult disinterest in usual foods and preference for lukewarm milk, suggest ambivalent interest in food. Her unsociable traits persisted from early childhood.

Case No. 3 was a 23-year-old, single, unemployed woman. Diagnosis: compulsive neurosis with schizoid features. She came to the clinic because of decreased food intake, crankiness about food, loss of weight, and irritable spirits.

The father was successful in earning money and paid little attention to the patient or to her mother. The latter, a tense woman, was extremely solicitous about the patient's welfare. There were no siblings. Delivery was difficult. The patient was never breast-fed. Early feeding of cow's milk was given by bottle. She was malnourished from the beginning. Thumb-sucking continued until six years. Her maternal grandfather walked the floor with her at night when she cried. Her mother coaxed her to eat, and when away from home would telephone to ask if she had eaten properly. From the start she was constipated and received enemas. At eight years, when her curls were cut, she developed a severe diarrhea. When she entered college at 18, she worried about facial acne and

treated it with frequent cathartics and a diet of spinach and lemon juice. She drank much coffee and smoked excessively. After two years of this régime, she had lost so much weight that she was advised to give up her schooling. For the next three years she continued to eat poorly, lost 30 pounds in weight and stopped menstruating. She spent much time reading cook books. She quarreled with her cook about the way of preparing foods. "I want the coffee the way I want it." She changed her milkman several times because of quarrels about the quality of the milk. She arose at 4 a. m. to spend several hours washing the spinach.

On admission to the clinic she was 30 pounds underweight. She gazed admiringly at her arrangement of a basket of colored yarn balls, saying, "Now I will pretend it is fruit and get the effect." She suggested that the dinner table be decorated with a colander of uncooked spinach, "for it is so beautiful." She complimented the dietician about the nice arrangement of food on trays and was delighted with the appearance of the "beautiful poached eggs." She wished to substitute cooking for the usual occupational therapy. She kept a scrapbook in which she pasted recipes for interesting foods. When extra nourishment was served she eagerly passed the crackers and cheerfully exhorted a fellow patient who was disinclined to eat, "Oh, come now, dearie. Look at the pretty color in your cocoa. That gives me an idea for a color scheme. Be a good girl and drink your cocoa." She preferred to eat only dirty, left-over foods, especially those that stimulated the bowels. She ate pieces of food that she had picked from the floor. She requested that her breakfast consist of shriveled oranges and stale rolls. When urged to eat the usual food, she devised clever methods of avoiding it. She disarranged it on her plate and used her fingers to pick it into small pieces. She hid scrambled eggs and sausages in her bloomers and scalloped oysters in her sleeves and bosom. She smeared butter and jelly in her underclothes. On being detected at these methods of avoiding food intake she was irritable. She secretly spat milk in the table napkin or on the floor or she allowed it to trickle down her chin onto her clothes. When tube-feeding was instituted, she resisted and weepingly said, "Oh, can't you see I'm afraid of it?" After meals she required careful obser-

vation to keep her from regurgitating. She attempted to reduce her weight by vigorously pacing the floor and by taking hot baths. She frequently requested cathartics. When these were denied, she requested a friend to send her favorite cathartic pills hidden in a powder puff. She drank hot water and went to the toilet as often as six times a day, straining at the stool for 20 minutes at a time. She attempted to remove the feces manually. She gained only six pounds during her four months residence in the clinic. After leaving the clinic she said, "I can't face it all" and attempted to jump out the window.

Summary: The early malnutrition, crankiness about food, constipation and crying spells were problems for her tense, oversolicitous mother who did not feed her by breast. The positive interests in food were the esthetic aspects of its preparation, arrangements and serving. She desired for herself only, dirty-left-over food of low caloric and potent cathartic value. She developed many ingenious tricks to avoid gaining weight. When thwarted in this she was irritable or sad and tried to kill herself.

Case No. 4 was a 14-year-old school boy. Diagnosis: dementia præcox, paranoid type. He was brought to the clinic because of alimentary disorders, emotional instability, rebellion against familial domination and peculiar false beliefs.

His illness began a year before admission, when his older brother came home from a school where he had been a leader in athletics. The patient was jealous that he was not allowed the same liberty as the brother in driving the family automobile. He complained of insomnia, constipation and fatigability. He was undertalkative. Following a herniotomy he stole automobiles and drove them without license. When his parents discovered this and reproved him, he took a large dose of luminal with suicidal intent. Thereafter he seemed more comfortable and was sent away from home to school. He got along nicely with the other boys until one of them told a risqué story about a half-grapefruit becoming hard when massaged. The patient did not understand the story. When the other boys teased him for not knowing that the half-grapefruit represented a female breast, he wept, developed constipation and gaseous eructations, and feared lest he die from another herniotomy that he

thought might be necessary. He then grew antagonistic to his parents, and destroyed his birth certificate. When he expressed the belief that he was hypnotized and that his food was poisoned, his parents brought him to the clinic.

On the paternal side the grandfather and a brother of the grandmother were alcoholic. The father slept poorly and suffered from night terrors and gaseous eructations. The mother resented each of her pregnancies. She stayed in bed often vomiting during the first two months of carrying her children. She indulged in lengthy arguments with her husband and usually won her point. The patient was her favorite, and she was very solicitous about his welfare. A brother three years older, the father's favorite, was more athletic and a better mixer than the patient.

During the fifth month of the mother's pregnancy with the patient her father died. For the next several months she was sad and frequently cried. Her milk supply was exhausted after a month. The patient readily accepted the bottle and soon was quite plump. There was no finger-sucking or gastro-intestinal disorder. "He was a most wonderfully easy child to raise." His older brother was a rebel, but the patient was so good at obeying parental rules and doing his school work that he never was punished. He was definitely obese until 12, when the secondary male sexual characteristics appeared. He was not good at athletics and did not mix well with the boys.

On admission to the clinic he was eight pounds overweight. He refused food because he thought it contained too much pepper and was poisoned. When spoon-feeding was attempted he did not swallow, or soon regurgitated what he had accepted. He indulged in loud gaseous eructations, saying, "Well, I brought that up. A little lemon water and soda to get the gas up." He was persistently constipated. "It's really my bowels that are responsible for my being here." At times he sighed and rolled his eyes piteously at the nurses. Again he spoke loudly and rebelliously about his parents. "My folks called me a drug addict. They took my genitals out, and I didn't want them to. If they want me to be a sissy, I will be a sissy, but I will be a nut too." He expressed sympathy for his father and criticism for his mother. "She just gypped him into

marrying her." He called his mother "an old hammerhead" because of her solicitous attitude about his food and clothes. As he improved, he ate ravenously and gained 11 pounds in weight. When his parents invited him to dinner in a restaurant, he chose the most expensive food on the menu, although he knew his family had suffered financial reverses. In spite of his mother's careful training in etiquette he reached across the table for what he wanted and he ate with his fingers. He ate quickly, taking large bites, chewing with his mouth open, and smacking loudly. If a dish were particularly to his liking, he served himself with an enormous portion, regardless of whether others had their just share and he was not disturbed by their ill-feeling toward him. He was particularly fond of hot chocolate drink and he demanded that the nurse serve him immediately. When she advised him to wait a while, he angrily declared he would never accept that drink again. In the discussion of this episode he understood for the first time why he was inclined to hurt himself and keep himself from getting what he wanted. An improvement in conduct followed. Previously when his attention was called to this tendency in regard to things other than food, he had smilingly nodded his head in agreement (a favorite mode of passively resisting therapy) without being able to apply the knowledge to similar incidents. On leaving the clinic after six months, he returned to school with his mouth stuffed with a package of gum. At school he continued to suffer with gaseous eructation and with constipation especially at the time of examinations. He made good marks, however. After giving a sound thrashing to a boy who needlessly teased him, he was respected by his fellow students. He no longer expressed peculiar ideas and was friendly with his parents.

Summary: Here the familial interest in the upper alimentary tract was present. The parental relationship was not harmonious. The mother resented her pregnancy and was sad during the latter part of it. The breast-feeding was inadequate but he accepted other foods without gastro-intestinal disturbances and grew obese. He gained parental favor by implicitly obeying their dictates. He did not appear to resent his passive rôle until puberty when there appeared sibling rivalry, conduct disorders, symbolic denial of his

family, frank criticism of maternal oversolicitude, and alimentary disorders. Being unaccustomed to rebellion and the resulting retaliation of others, he succeeded only in hurting himself with his aggression.

Case No. 5 was a 15-year-old, male student. Diagnosis: dementia præcox, catatonic type. He was brought to the clinic because of alimentary difficulties, malnutrition, mood disturbances, poor concentration of attention, and confusion of thoughts.

Two years before admission to the clinic and a year before physiological puberty he attended a religious ceremony in which he was told that he had become an adult. During the ceremony he was so fearful that his legs shook. Following this he ate poorly and suffered from a slight temperature elevation, diarrhea, and vomiting. These symptoms persisted two years and no physical basis for them was found. Careful examinations including X-rays of the chest and gastro-intestinal tract and studies of the intestinal content for unsual microorganisms and undigested food were negative. When given a special diet to combat his diarrhea and weight loss he irritably noted that his food was different from that of the rest of the family and ate less than usual. He grew angry with his younger, more aggressive brother when the latter spoke loudly or refused to obey his parents. He found difficulty in concentrating his attention on his school studies. Because there was some improvement in his physical symptoms when he visited away from home, he was sent to boarding school three months before admission to clinic. He soon talked of observing some adolescent male sexual play and appeared so confused that he did not admit the identity of his own mother.

His maternal grandfather suffered from prolonged attacks of diarrhea for which no organic basis could be found. His mother was a tense, domineering person subject to spells of weeping and irritability. She was oversolicitous about his welfare and was definitely more fond of his only sibling, a brother seven years old. She was nauseated during the entire time that she carried the patient, and had a functional diarrhea that lasted for 12 years after his birth.

He was breast-fed for one month. Bottle feeding was accepted without gastro-intestinal disturbance, and normal weight was maintained. However, he had bitten his nails and wet the bed until the present time. His mother, fearing he would be injured, forbade him to play in the street or to have fights with the boys. He followed her dictates and played by himself. When the boys teased him he clowned in their presence to gain favor. He was small in stature and a poor athlete. He excelled only in his scholastic work.

On admission to the clinic he was 24 pounds underweight. He assumed fixed postures, showed waxy flexibility, retained saliva, and wet and soiled himself. He said he felt the movements of a baby in his abdomen. He expected the delivery to occur when he received colonic irrigations. He said he did not eat because he was nourished by a large salivary gland located in his head. He cheerfully remarked that his head might be cut open to prove the existence of the gland.

His illness had progressed for two years before he was brought to the clinic. He gained 12 pounds in weight after five months of treatment but his mental condition did not improve.

Summary: Here one saw the familial intestinal disorder. The breast-feeding was deficient. He passively accepted artificial food and there was a passive reaction to life until puberty. Then came the alimentary troubles, malnutrition and bizarre thinking.

Case No. 6 was a 30-year-old married woman. Diagnosis: psychopathic personality, without psychosis; alcoholism. She came to the clinic because of excessive drinking of alcoholic beverages, irritable spirits and rebellion against her family's domination.

Her alcoholism began at 18, when she became economically independent of her family. She was resentful that her father's poverty necessitated her working. In spite of his prohibitions she drank alcoholic beverages excessively and associated with people of whom he disapproved. When intoxicated she was irritable, argued with her parents, berated her husband for his poor earning capacity, and threatened to desert her child. Then after a few more drinks, she would fall asleep with her hat on, and sometimes burn holes in the blankets with her cigarettes, and be incontinent of urine. When

her husband refused to finance her drinking, she either drank vanilla extract or borrowed money from taxi drivers for more palatable liquor. She found it difficult to admit her alcoholism and often had an alibi for her unusual conduct. She finally deserted her husband, returned to her family, and continued excessive drinking until she was brought to the clinic.

During her childhood her father, a capable public speaker, suffered from tantrums in which he threatened to beat and choke her mother. The patient protected her mother by threatening to scream for the neighbors' help. Her mother was tense, undernourished, and dissatisfied with her husband's small income. She despised cooking and the family meals often consisted of tea and bakery cake. When she slept poorly at night she consumed tea and toast, believing that these acted as a somnifacient.

Patient was breast-fed three weeks. Her bottle-feeding was accompanied by crying, vomiting and diarrhea. These symptoms ceased at eight months when she was placed on more solid food and achieved her proper weight. She wet the bed until five years of age. Her mother considered her a model child because "she did everything I said" until her present illness. The patient from early childhood enjoyed cooking delicious food. After marriage, at the age of 22, she prided herself on cooking unusual dishes. Nothing made her happier than to have her guests compliment her on the excellent food she served.

In the clinic she weighed 30 pounds less than her proper weight and 8 pounds less than usual. She slept poorly because she lived "right across the street from a hospital (a fact), and all I could hear was the poor little babies crying. I wanted to go over and help them." She was restless and wished to go home. "If I'm inactive, I'm like a bean on a hot griddle, I always have to be very active anyway." When her requests to be visited by her family or to go home were not granted, she stamped her foot and had brief crying spells. She was irritable when required to wait for her morning cigarettes. She often complained of sore throat, of which there was no objective evidence. After a month of treatment she persuaded her family to take her home, promising to avoid alcoholic beverages.

Summary: Strong upper alimentary tract interest occurred in the parents. Inadequate milk supply was associated with marital disharmony. The patient accepted artificial liquid food but with crying spells, vomiting, and diarrhea. After the introduction of solid food she reached her proper weight, obeyed her parents and delighted in supplying good foods for others. When forced to earn her own living, she again became rebellious and obtained the desired alcoholic beverages in spite of the dictates of parents and husband.

Cases of Excessive Breast-Feeding

Four examples of patients with excessive amounts of breast-feeding were selected to show the sequence and relationship of events in the life history of these cases. In those whose early history was accurately recorded, emotional disorders appeared in early as well as later life. In addition to the nervous symptoms shown by the patients with inadequate breast-feeding, there were ideas about good and bad food, food rituals, and a crankiness about the quality of food.

Case No. 7 was an eight-year-old boy. Diagnosis: psychoneurosis—compulsion and anxiety features. He entered the clinic because he presented a feeding problem and suffering from fears, compulsions and tantrums.

He was breast-fed 14 months. The nursing was prolonged because his mother enjoyed it and she thought a subsequent pregnancy that she did not desire was impossible during lactation. His later feeding was a problem. He did not give up the bottle until six years of age, when his younger sibling arrived. He required spoon-feeding by his mother until admission to the clinic. Soiling stopped at four years. He was often constipated and resisted the enemas that his father gave him. At two years of age his parents found him touching his genitals. They rebuked him and gave him a crayon suggesting that he draw pictures. Thereafter he showed little interest in his genitals, and he had spells of attempting to touch the eyes of others and of drawing peculiar animals.

On admission to the clinic his mental age, according to the Binet-Simon test was six months below his physiological age. He weighed

nine pounds more than his proper weight. He refused to eat various foods, including eggs, bananas, and asparagus. He attempted to eat paper, sand, and his nasal secretion. He played games with dolls. One of the games was to feed milk to the babies. To each of them he offered milk, commenting on its quality. "What's in here? It's too sour. And this one is too sweet. This one is no good. And this has poison. And this one has very naughty poison. And this"—he smiled happily and drank the milk—"is good." In discussing his feelings towards a six-year-younger brother, Jackie, from whom he hated to be separated because of a fear lest Jackie be eaten by wild animals, he said, "Babies are a nuisance. They don't know anything. When Jackie sucked on mother's titty (here patient eagerly licked his lips) he cried. Jackie cried when mother gave him titty. He wanted to go to sleep. No, he didn't want no titty." (Why?) "When I was little I liked titty. I asked my mama if it tasted sour. She asked me if I wanted titty. I said, 'No. It tastes sour!' " (What does it taste like?) "Poison." In a game with dolls he fed them with milk. When they refused the milk, he said they were bad and must go to bed without supper. To the good dolls who drank their milk, he fed eggs, sausages, and bread, "and they ate everything."

At times he felt compelled to draw. "Now I must draw. I have to draw." While drawing pictures of mutilated animals and of animals eating each other, he appeared excited, panted, and bit his fingers. He frequently tried to touch the eyes of others, saying, "I will take your eyes out. I will make them bleed. I will bake them. I will eat them." When the nurse did not allow him to touch her eyes, he appeared angry, bit his fingers, pressed his nose against the table, licked it, and ran to the wall, pounding his head against it.

Summary: Excessive breast-feeding and unduly prolonged bottle-feeding. Difficulty of finding acceptable foods, and an interest in foods that are not usually acceptable. Possibly the prolonged bottle-feeding and the overdiscriminating attitude toward solid food may have been associated with difficulty in giving up the more satisfying breast-feeding. The fantasies about the good, bad, sweet, sour, and poisoned foods were apparently related to varying emo-

tional attitudes toward breast-feeding and were stimulated by jealousy at observing the breast-feeding of the younger sibling.

Case No. 8 was a 30-year-old financial expert. Diagnosis: psychoneurosis, psychasthenia. He came to the clinic because he was afraid of his compulsive thoughts of murdering his wife.

His more evident illness was of two years duration. He felt compelled to think of murdering his wife and was fearful lest he actually do this. He feared lest he kill anyone who spoke while he was lighting or extinguishing his cigarette. When these difficulties interfered seriously with his business he came to the clinic.

He was the fourth of six siblings. His mother fed him by breast for two months, and he was then breast-fed by a wet nurse for 18 months. There was no evidence of gastro-intestinal trouble in the early history. Likewise there were no data concerning his early emotional feelings for his mother. However, as an adult he seldom saw her and did not express kindly feelings for her. Upon the death of his father the patient, then eight years old, and his two-year-old brother were placed in an orphanage. There he arranged his duties so that he worked with food and he secretly provided himself and his brother with the better type of food served to the women employees. He delighted in teasing these women by threatening to drop baskets of clothes from balconies onto their heads. At 20, following a spell of upper abdominal pain, gaseous eructations, and constipation, his gallbladder and appendix were removed. His relief was only temporary and he attributed the subsequent attacks to the rare occasions when he substituted for his usual simple diet the luxurious, imported foods and liquors such as he liked to provide for his friends. On admission to the clinic he weighed five pounds less than his proper weight. He talked so lengthily and persistently that it was difficult to terminate interviews. He frequently argued and quarreled with others. While talking he protruded his large lips, licked them, and made smacking noises. He wished to smoke excessively. He delighted in providing for his fellow patients luxurious imported foods, of which he ate sparingly. He suffered from attacks of upper abdominal pain, gaseous eructation, and constipation. He believed these symptoms were due to fearful compulsive thoughts of "murderer's dish" bothering him

when he attempted to eat. When he recalled a previous physician's advice to avoid all meats except ham, lamb, and chicken, he said he suffered from the abdominal symptoms if he ate a small piece of roast beef, but consumed three ham sandwiches with impunity. Again he believed that his stomach symptoms were due to food served by the clinic, so he accepted only a little tea and toast. Outside of the clinic he ate full meals. He talked of the cathartic efficacy of a certain variety of pear. He bought cascara from a drug store because he thought it "purer" than that prescribed in the clinic. He thought chicken patties and spaghetti with sauce were dirty and preferred unmixed foods such as roast lamb. Because of his ideas about food and his gastro-intestinal discomfort he ate insufficiently and was 14 pounds underweight when discharged from the clinic.

Summary: Prolonged breast-feeding, and the early drive to acquire the good food of the women employees. The later ambivalent feeling to women and the ideas of the good-bad, pure-dirty foods were quite similar to those of Case 7. His nutrition was seriously compromised by the thoughts and discomfort associated witn eating food.

Case No. 9 was a 25-year-old lawyer. Diagnosis, psychoneurosis, reactive depression. He entered the clinic because of sad spirits and gastro-intestinal difficulties.

The illness developed when he entered a professional school where there were no restrictions on the amount of time required for study. He made poor marks in his studies. He consulted physicians about constipation and stomach discomfort. When his father lost most of his money and developed a serious physical disease, he feared lest his father die and was afraid to take his bar-examinations. Finally when sadness of spirits and thoughts of suicide intervened, he sought treatment in the clinic.

He was an only child. Breast-feeding lasted two years. Infancy and childhood were marked by "colic," constipation, and tantrums. His mother nagged him to eat sufficiently, saying, "if you don't eat enough you won't be strong." He stubbornly insisted on having his own way. The other children called him "cry-baby." His childhood was recalled as just one series of frustra-

tions. He was allowed to buy only one type of candy, when his friends chose what they wanted. He was required to wear heavier clothes than others because his parents feared lest he catch cold. As he grew older, he made good marks in school, and he was proud that he would never have to earn his own living because of having a rich father.

On admission to the clinic he was 14 pounds underweight. He covered his coffee with a film of cream by pouring it over a spoon that touched the surface of the coffee. He required a glass of warm milk as soon as he retired and believed the nurses' occasional slowness in providing this was due to their personal grudge against him. With each meal he drank a glass of milk. This, as well as other liquid nourishment, such as soup and coffee, had to be of a certain degree of mild warmth before he accepted it. He required that a glass of hot and cold water be set at his table place for the purpose of diluting his liquid foods to the proper degree of warmth. He was irritable when these food rituals were interfered with. When irritable he bit his fingers, stuttered, and smoked excessively. He grew particularly angry when it was discovered that he had hidden several packages of cigarettes for use in case he should exhaust his regular allowance. Following blood-letting he was nauseated and could not eat breakfast. If frightened "it always goes to my stomach." After meals he complained of feeling "dull and soggy," so he couldn't think clearly. He felt cheerful, light and free when he had a satisfactory bowel movement. This he seldom achieved, for he usually felt hurried by his regular schedule of clinic activities. A prerequisite for a "good movement" was the assurance that he had all the time he wished for the procedure. He spoke bitterly of his mother's irritable, nagging, worrisome disposition and wept as he talked of the possible death of his father, whose kindly, generous qualities he highly praised. When discharged from the clinic, he weighed five pounds less than his proper weight.

Summary: Prolonged breast-feeding, and the negative feedings for the irritable, oversolicitous mother who quarreled with her husband. Gastro-intestinal disturbances and tantrums were present during the prolonged breast-feeding. He was free of physical discomfort and successful in work until he was faced with

adult responsibilities. Then appeared the decrease in his working ability, alimentary disorders, interest in peculiar food rites, and unstable emotions that were affected by upper and lower gastro-intestinal stimuli.

Case No. 10 was a 43-year-old business executive. Diagnosis: psychosis due to alcohol, delirium tremens. He was brought to the clinic because he drank alcoholic beverages excessively and had visual hallucinations.

Following the birth of a son a year before admission to the clinic his alcoholism increased, and he ate little, soon losing 40 pounds in weight. He paid less attention to his work. In an effort to stop his heavy drinking, he accepted a diet of sherry wine in milk. He suffered from constipation. His hands grew tremulous and he had fearful visions of snakes as well as pleasant ones of beautiful semi-precious stones.

His father was a spree drinker and was subject to depressions. His mother weighed two hundred pounds. He was an only child. Breast-feeding lasted two years. He finished college before the age of twenty. In spite of drinking alcoholic beverages excessively for 12 years, he was a successful business executive.

When he entered the clinic he weighed eight pounds less than his usual weight, which was seven pounds more than his proper weight. He was forbidden alcohol while in the clinic and for a time refused all fluids, saying he believed they contained harmful medication. On discharge from the clinic recovered from his psychosis he was 15 pounds overweight.

Summary: Familial tendency to unsual upper alimentary tract interest and the prolonged breast-feeding. It was not until his son was born that alcoholism interfered with his nutrition and work. When he was denied alcohol, he refused all fluids, explaining his peculiarity on the ground of believing the fluids contained a harmful medication.

Cases of Adequate Breast-Feeding

Three examples of patients with adequate amounts of breast-feeding and undue interest in the upper alimentary tract were selected. In each patient the familial interest in the upper gastro-

intestinal tract was marked and the mother was unduly interested in the child. The nervous symptoms were similar to those of patients with inadequate and excessive amounts of breast-feeding.

Case No. 11 was a 31-year-old actress. Diagnosis: manic-depressive psychosis, perplexed type. She was brought to the clinic because she tried to kill herself while in a perplexed hallucinated state.

Three years before admission to the clinic her lover went abroad. She was mildly sad, found it difficult to secure work, and ate excessively, gaining 20 pounds more than her usual weight. She drank a mixture of gin and absinthe, not only at the cocktail hour but during the day. She kept company with a rich old man who advised her about her financial investments. A month before admission she received word that her lover was returning to this country and was still interested in her. She stopped her drinking and quickly reduced her weight by 20 pounds, through rigidly following a diet of fruit, bran and milk. During the week before admission, she drank gin-absinthe cocktails and indulged in amorous play with her lover. While intoxicated he beat her, rebuked her for her relationship with the rich old man and left her. Then she quickly developed a perplexed, hallucinated, sad state in which she attempted suicide by drowing.

The maternal grandmother and the mother were obese and enjoyed their food. They were fond of long arguments. The mother married in spite and became interested in another man when the patient was 10 years old.

The patient was an only child. Breast-feeding lasted nine months and she was a plump baby. Being the only child in the family, she received much attention from her mother and several older relatives who lived nearby. The mother says, "They found little ways of diverting her so I wouldn't punish her." She was willful and stubborn. The father's business required his absence from home for long periods. The patient was not fond of him but was unusually devoted to her mother. On reaching adult years, she supported her mother who accompanied her on business trips and made the necessary arrangements about traveling, food, and lodging.

The mother tried to avoid interfering with the patient's personal liberty and their relationship was apparently harmonious.

On admission to the clinic her weight was normal. She appeared perplexed and shyly accepted the physician's hand, allowing herself to be led about the room. She sat on the bed and restlessly kicked her feet back and forth. Voices said that her mother was starving. She ate poorly and it was necessary to spoond-feed her. Later tube-feeding was required. The latter she often regurgitated. Her reason for refusing food was, "I haven't any money. Really I haven't. I can't pay for it." She was constipated, and when colonic irrigations were given voices accused the nurses of impacting her bowels by the insertion of feces in her rectum. As she recovered she ate less than the usual person because she wished to maintain her slender figure at 11 pounds less than her proper weight. She considered this weight an asset to her work.

Summary: In the maternal line were obese people, overly interested in their food, and in talking. The mother provided an adequate supply of milk for the patient, whose early life was free of gastro-intestinal disturbances. The excessive interest of the mother and maternal relatives and the continuance of the child-mother relationship produced no apparent early nervous symptoms. When there was the loss of a man in whom she was interested there appeared the mildly sad spirits, overeating and excess alcoholic intake. Following the second loss of this man, the more evident mental sickness developed. Sad spirits, refusal of food and the imagination of her mother starving were prominent symptoms of the illness.

Case No. 12 was a 20-year-old female college student. Diagnosis: manic-depressive psychosis, circular type, manic phase. She came to the clinic because she was elated, overactive and rebellious against her usual social regulations.

She had suffered from depressions and elations of spirits for one and one-half years. The elated phase of illness in which she entered the clinic appeared when she planned to leave home and attend her first year of college. She bought unnecessary clothes, made too many social engagements with boys, talked more than

usual and appeared very cheerful or irritable. She at times spoke kindly of her mother and again was rebellious of her solicitous attitude. "It was said I was in a drug store acting as if I was drunk, with four or five boys, raising merry Ned. I drank some hot coffee, pouring it into my glass to cool it. It made me mad that they should think I was drinking. I had had no liquor. Then I started going out with boys who drank. I always act crazy and talk a lot, and then they would think I was drinking. Mother was worrying about who I was with and if I was drinking too."

Her paternal grandfather and father took frequent doses of medicine for minor ailments. Her father, a periodic drinker, often complained of indigestion. There was no open friction between the parents, although the mother admitted disliking the father's peculiarity of nervously tapping his hand and foot against nearby objects. The mother, an obese woman, thought her children better than others. She was oversolicitous of their welfare and encouraged a closely-knit family group. She was proud of serving the best quality of food and drink in her home. The family enjoyed automobile trips during which they amused themselves by singing and eating good foods. Although she was devoted to her three-year-older brother, she was jealous of the greater freedom that her parents allowed him because he was a boy.

She was breast-fed nine months. During the first month of this feeding, she had frequent spells of "colic" that were relieved by the ingestion of peppermint water. She walked at three years and she sucked her thumb until the age of four in spite of attempted corrective measures of tying the thumb with cloth and covering it with alum and black paint. She was a stubborn child and had tantrums when her mother spanked her. As she grew older she was very fond of the good food that was abundantly supplied in her home. She was obese since the age of 15. In spite of internal glandular therapy, she ate excessively and continued to gain weight.

On admission to the clinic she was 20 pounds overweight. She made frequent trips to the smoking room, where she requested cigarettes. She complained that the coffee was not strong enough. She requested that she be allowed to have more than the usual num-

ber of eggs for breakfast. She was irritated and refused supper when not allowed to wear pajamas in the dining room. She often complained of vague head discomfort, and requested aspirin. She wished to reduce her weight to compete with other girls for the attention of boys. In spite of receiving an anti-obesity diet, she gained seven pounds during her residence in the clinic. She secretly ate candy that had been sent to other patients and traded with another patient her evening nourishment of an apple for the usual cup of cocoa. Her family sent fruit to her, and during periods of irritability she gorged upon it, eating as many as nine apples in one day, throwing the cores on the floor. Following these periods of overeating, she complained of nausea. On visits outside the clinic with her family she stuffed herself with food. When she attempted to adhere to her anti-obesity diet, she complained, "I feel kind of weak and sick to my stomach. I haven't eaten anything much today, as I am trying to lose weight. I'm all worn out from not eating anything."

Summary: Here the familial overinterest in the upper alimentary tract was present on both the paternal and maternal sides. The mother was not well adjusted to her husband's peculiarities. She was tensely oversolicitous about the patient's welfare, catering to her appetite and accustoming her to large quantities of the best foods. The father encouraged her to take medicine for her minor ailments. These factors may have influenced the excessive upper alimentary tract interest that was associated with her mood disorder.

Case No. 13 was a tall, muscular, 25-year-old business executive. Diagnosis: without psychosis, alcoholism. He came to the clinic because of alcoholic sprees in which he worked inefficiently, misappropriated money, and thought of killing himself.

He began to drink alcoholic beverages socially at 18 and by the age of 23 was drinking whiskey in the morning to relieve the headache, nausea and tremors that resulted from the drinking of the previous night. He held minor positions, many of which were secured by family influence. After marrying at 23, his drinking increased. He then went on sprees of several months duration. Between sprees he was penitent and begged his wife to accompany him

from work to avoid the temptation of drinking at public bars. When intoxicated he preferred to associate with inferior men, and after his funds were exhausted he borrowed money from the cash box of his employer, forgetting or being unable to replace the money next day. His mother paid for these expenditures. During the latter part of his sprees, he feared lest he kill himself or desert his wife. Following the birth of a son, he drank still more. His mother then persuaded him to come to the clinic.

His father, a capable political executive, was well known for his biting, sarcastic, humorous manner of talking. He realized the mother's lenient attitude toward the patient and, therefore, handled him more firmly than the other children. On the maternal side the great-grandfather was alcoholic and the grandfather was a gifted public speaker. The mother, who loved and respected her husband, considered the patient her favorite child. He was more fond of her than of his father. Because he was the youngest of four siblings born in quick succession, he received more prolonged attention from his mother than did the other children.

His mother was well and happy during the pregnancy. He was breast-fed nine months. His mother said she received great mental contentment and most delightful physical sensations in her breasts during the act of nursing. He was the easiest of her children to rear. As a baby he was plump and slept quietly between feedings. He did not suffer from gastro-intestinal disorders. He gracefully accepted the transition from liquid to solid foods. However, one of the earliest memories elicited from him was that at the age of five, when he voluntarily wet the bed at night. Following this incident his mother allowed him to sleep with her until she discovered that he attempted to suck at her breasts. His feeling of frustration and not understanding why his attentions were repelled, was recalled quite vividly. Other early memories were of observing a mother goat suckling her young and of the time when his family kept a cow and he had all the milk he wished to drink. The family were not poor people, but his demands for milk were decidedly in excess of what the usual family budget allowed. At school he sang in the glee club. At 17 he became interested in girls, preferring those with large breasts. An important part of his love making

consisted of sucking and nibbling on the breasts, "because it stimulates the woman." He was reasonably fond of food and ate uncomplainingly what was put before him. He was particularly fond of milk and found that interest associated with his alcoholism. "After drinking for a long time, I suddenly feel a tremendous urge to drink milk. When I have a great thirst, I drink milk and it makes me feel as if I had eaten a meal. It is the beginning of the end of liquor when I drink milk. I finally drink milk the first thing in the morning and between my meals as well as on the last thing at night. I get away with three to four quarts a day."

On admission to the clinic, his weight was normal. He was more cheerful and agreeable than the usual alcoholic. He ate and slept well and was free of physical discomforts. When interviewed the day after admission he said, "I can't think of anything to report. As I went to sleep, I had a thought of not going to work today. I slept all right." Only occasionally did he grumble. "My old lady pulled a fast one on me, getting me to come into this place, but I will not be a sucker all my life."

Summary: On both the paternal and the maternal sides there was a strong upper alimentary drive. The mother's unusually positive interest in the act of nursing and the excessive amount of attention that she gave him, the youngest of her children, was associated with his prolonged interest in her breasts and those of other women. When grown his love making interesting was directed toward giving pleasure to women by his oral stimulation of their breasts. The unusually great love for milk in childhood, the adult alcoholism and the substitution of milk for alcohol toward the end of a drinking spree suggest his close psychological association between the two fluids, milk and alcohol. This association was expressed by another spree drinker who jokingly said, "Scotch whiskey is almost as good as mother's milk."

Summary and Conclusions

From over more than five hundred consecutive admissions to a psychiatric clinic 172 were selected because of the available detailed information regarding early childhood development for special study of the relation of infant feeding, digestive disturbances

and personality disorders. This group was composed of cases in which the breast-feeding was (1) inadequate, (2) excessive, (3) adequate.

The results of the study seem to permit the following conclusions: (1) Inadequate or excessive breast-feeding is undesirable from both the physiological and the psychological viewpoints. (2) Both of these extremes in infant feeding are common. It was inadequate in 49 per cent of the cases and excessive in 9 per cent. (3) A strong familial interest in the upper alimentary tract and a faulty maternal emotional reaction to the child are most important factors in functional gastro-intestinal and emotional disorders.

REFERENCES

1. Newell, H. W.: The psychodynamics of maternal rejection. Amer. Jour. Orthopsychiat., 4: 387.
2. Levy, D. M.: Maternal overprotection and rejection. Arch. Neurol. and Psychiat., 25: 886.
3. Holt and Howland: Diseases of Infancy and Childhood. D. Appleton and Company, New York and London, 1927, p 118.
4. ibid, p. 120.
5. Levy, D. M.: Experiments on the sucking reflex and social behavior of dogs. Amer. Jour. Orthopsychiat., 4: 203.
6. Grulee, C. G., et al: Breast and artificial feeding; influence on morbidity and mortality of 20,000 infants. Trans. Sect. on Pediat., A. M. A., 1934, pp. 25-35.
7. Henry, G. W.: Gastro-intestinal motor functions in manic-depressive psychoses. Amer. Jour. Psychiat., 11:19.
8. ——: Gastro-intestinal motor functions in schizophrenia. Amer. Jour. Psychiat., 7:135.
9. Holt and Howland: See reference 3, p. 138.

PROGNOSIS IN DEMENTIA PRAECOX

A Comparative Study of Present Results and Those Obtained from Hypoglycemic Treatment

BY DUNCAN WHITEHEAD, M. D.,
ASSISTANT PHYSICIAN, UTICA STATE HOSPITAL, UTICA, NEW YORK.

The advent of Sakel's hypoglycemic treatment for dementia præcox has brought forward the question of the prognosis in this condition for examination under a new light. The concept of this symptom-complex as elucidated by Kraepelin and his students has caused emphasis to be placed on the accompanying deterioration and consequently on chronicity of the illness. That this is the more usual course is common experience, but the emphasis is so heavy and has so pervaded diagnostic and prognostic thinking that in some circles, dementia præcox and chronicity are very closely associated with each other; one has implied the other and the chief differential diagnostic point between dementia præcox and manic-depressive psychosis has become the course which the condition follows through the lifetime of the individual patient. As a necessary corollary to this method of thinking is the variously expressed opinion that any form of treatment which causes improvement or recovery in a few cases is of itself extremely valuable and should be employed in every case or the physician's duty to his patient is not properly discharged. This reasoning does not take into consideration that there is a recovery rate, an improvement rate and the possibility of a favorable prognosis in dementia præcox.

What the exact prognosis is has been variously stated. It has not been definitely determined but appears to depend upon the circumstances in each individual case. Kraepelin[1] stated that he found real improvement in 26 per cent of his cases if those whose duration was only of a few months were considered. He[2] further concluded that 8 per cent of the hebephrenic type and 13 per cent of the catatonic type showed an apparent recovery to have taken place. Although he[3] later modified his opinion to the statement that "lasting and really complete cures of dementia præcox, though they may perhaps occur, still in any case are rarities," the view of

a degree of favorable prognosis has persisted, especially for the more acute and early-recognized cases and more particularly for the cases of the catatonic type. Among the more recent contributions stressing these points are those of Strecker and Willey,[4] who report 25 out of 187 cases of dementia præcox, or 13.3 per cent, as recovered. Later, the same workers[5] present 38 of these cases as recovered after a follow-up period of five years. Sullivan[6] laid stress on the recoverability of cases in which the onset was acute. Hinsie[7] in reviewing the literature states that spontaneous remissions occur in roughly 15 per cent of cases of dementia præcox, predominately in acutely developing syndromes and among women. Bellinger[8] in studying the outcome of 37 cases of catatonia found 16 per cent recovered and 9 per cent recovered with defect. Lewis and Blanchard[9] analyze 100 recovered cases of dementia præcox finding, among other facts, that the duration in 80 cases was of less than one year, in 14 was about one year, in 6 approximately two years and in no case was more than two years.

In the published reports concerning the results from hypoglycemic treatment the cases have been divided entirely on the duration of symptoms from the first noticeable change in the personality to the time of commencing treatment. Glueck[10] in a report concerning the results of Sakel and Dussik in Vienna states that, of 104 cases, those with a duration of less than six months showed 88 per cent good recovery and 70.7 per cent complete recovery and those with a duration of over six months showed 47.8 per cent good social recovery with 19.6 per cent complete recovery. Glueck[11] again states that over three-fourths of the patients who have been ill less than half a year make complete recoveries and over 68 per cent of those who have been ill less than one and a half years are similarly benefited.

Müller[12] of Munsingen is quoted as reporting 300 cases from Vienna and Switzerland with the following results:

Less than six months duration—89.8 per cent improvement of which 75 per cent were recovered.

Between 6 and 18 months duration—82 per cent improvement of which 50 per cent were recovered.

Over 18 months duration—45 per cent improvement of which 0.5 per cent were recovered.

This report is the most inclusive and is apparently a composite of the figures from the two centers. Accordingly it will be used for comparative purposes.*

No similar groupings have been found in the literature either for other forms of treatment or for spontaneous remissions. Therefore, although these results are striking and compelling, the opportunity for comparative studies does not now exist as one attempts to answer the second of the ever-present questions concerning a new form of treatment, What can we expect this treatment to accomplish and how does it compare with present methods?

Because of this situation and also in searching for answers to other questions, the following statistical study was made when hypoglycemic therapy was instituted at the Utica State Hospital. Although the series of cases is small, it does present sufficient data to show the trends which have been established in the past.

I. *Prospective candidates for treatment per year.*

Although a survey of the women's continued treatment service showed a population of 49 per cent dementia præcox, it was found that only 17 per cent of the admissions (inclusive of readmissions and transfers) during the fiscal year 1935-36 were so diagnosed. The total number of cases admitted in that period was 90, divided into the subgroups as follows:

Hebephrenic	49, or 55 per cent
Paranoid	26, or 28 per cent
Catatonic	12, or 13 per cent
Simple	3, or 4 per cent

Since the hebephrenic and simple types are said to be relatively unsatisfactory for the special therapy due to the longer duration of

*Since the preparation of this article, there have appeared two further reports of the results from hypoglycemic therapy:

Wilson, I. G. H.: A study of hypoglycemic shock treatment in schizophrenia. His Majesty's Stationery Office, London, 1937, pp. 48-52.

Wortis, J.: Sakel's hypoglycemic insulin treatment of psychoses—a collected abstract. Jour. Nerv. and Ment. Dis., 85:5, pp. 581-590. May, 1937 (with extensive bibliography.)

The general results approximate closely those reported by Müller, which can therefor still be used for this comparative study.

symptoms and the more gradual onset in these two varieties, there remain but 38 cases admitted each year who promise to receive any great degree of benefit from the procedure. This does not exclude those whose physical condition is too precarious to withstand the rigors of hypoglycemic coma nor those for whom permission cannot be obtained. This latter group has so far been very small but such cases have been encountered.

In the selection of cases for treatment, more stress has been placed on duration of symptoms than on types of symptoms. Accordingly the group of dementia præcox admissions was analyzed from this point of view. Using the headings that have appeared in the literature, the following results were obtained:

Less than 6 months—36, or 41 per cent
From 6 months to 18 months—13, or 15 per cent
Over 18 months—38, or 44 per cent

From these two groups of figures, we can conclude that in this particular hospital there are admitted each year from 38 to 49 cases in which the optimum results could be expected from hypoglycemic therapy, basing this expectation on the available published statistics of results in this form of treatment. It is apparent, then, that the hope of the method lies not in aiding a large number of patients immediately but in gradually decreasing the number of inmates over a long period of time by preventing the accumulation of chronic cases. This anticipation will be substantiated when the method has been shown to furnish either a lasting remission or a permanent recovery.

II. *Present results tabulated for comparative purposes.*

a. *By standard subgroups.*

The 90 cases admitted during the fiscal year 1935-36 were further analyzed as to present condition after at least six months of observation and treatment in every case; that is, these figures were gathered six months after the close of that fiscal year. In recording the results the standard classifications of the Department of Mental Hygiene of the State of New York were used—recovered, much improved, improved and unimproved. So far as possible the estimate of present status was taken from the official

records, otherwise the opinion of the psychiatrist in charge of the patient's care was used and he was cautioned to be as conservative as possible in his estimate.

The results are indicated in the following table:

	Recovered		Much improved		Improved		Unimproved	
	Total	Per cent	Total	Per cent	Total	Per cent	Total	Per cent
All dementia præcox	8	9	6	7	18	20	56	62
Hebephrenic type	4	8	3	6	8	16	33	67
Paranoid type	0	..	2	8	5	19	18	69

Catatonic type and simple type—the total number of cases here was too small to be of value for statistical purposes.

Compiling these under the headings used in reports concerning results from hypoglycemic treatment we find that our total results after one-half to one and one-half years of hospitalization under present forms of therapy show 36 per cent improvements in dementia præcox of which 9 per cent are recoveries.

b. *By duration.*

These figures cannot be compared with the results published following the use of hypoglycemia since they do not consider duration. In an attempt to make such a comparison possible, the present group of cases was analyzed from the standpoint of duration alone, no attention being given to the subdivisions of the diagnosis. The following table gives the results:

	Recovered		Much improved		Improved		Unimproved	
	Total	Per cent	Total	Per cent	Total	Per cent	Total	Per cent
Less than six months	8	22	1	3	9	25	18	50
From 6 to 18 months	0	..	3	23	2	15	8	62
Over 18 months	0	..	0	..	9	23	29	77

Expressing these in a way analogous to the published results of hypoglycemic therapy, the following results are indicated:

Under six months duration—improvement 50 per cent with 22 per cent recoveries

From 6-18 months—improvement 38 per cent with no recoveries

Over 18 months duration—improvement 23 per cent with no recoveries

Comparing these results with the figures from hypoglycemic therapy (see page 384), one finds them to be roughly parallel with an improvement rate approximately one-half that obtained by the new method. There is a wider discrepancy between the recovery rates in favor of hypoglycemic therapy. This type of treatment would therefore appear to hold twice the hope for improvement that present methods do and to more greatly increase the outlook for recovery.

III. *Problems presented by term "recovery."*

The use of the word "recovery" has long been a subject of debate in psychiatric circles chiefly because of the difficulty in establishing criteria for the correct use of the term and the differences in the criteria which have been established in various clinics and hospitals. Many substitutions have been used, such as "social recovery," "complete remission," "partial remission," in order to avoid the use of the questionable term, recovery. Yet the term is used in connection with the results of hypoglycemic therapy and therefore must be considered in comparative studies. The term as used in the New York State Department of Mental Hygiene indicates a return to the prepsychotic personality with sufficient insight for realization that a mental illness has occurred and that its inception was due to internally disordered mental functioning. For the sake of consistency, it is felt that this definition should continue to be used in this hospital. To establish these criteria in any individual patient it is absolutely essential that considerable probing into the mental content be carried on or the estimate is unsatisfactory and very apt to be in error. However, Sakel *cautions against such probing on the very substantial ground that it appears to interfere with the process of recovery,* and no one is in a position to disregard his observations. We are, therefore, impaled on the horns of dilemma in undertaking to evaluate our own results or in comparing them with others.

In the author's experience, one case stands out to illustrate this difficulty. A school teacher of 38 years who had shown paranoid delusions, seclusiveness, irritability and an exaggerated sense of self-importance over a period of three years, received hypoglycemic

treatment. She was given 34 periods of coma each extending about one hour with the coma being rather profound. Near the conclusion of the series, she showed a remarkable personality change, becoming more friendly, more open and much more aggreable. Contrary to her former custom she was now very cooperative on the ward. When visited by her father to whom she had shown a marked antagonism and whom she usually received with much bitterness, she was friendly and affectionate, displaying an interest in her home, friends and neighbors which amazed him. Close observation revealed no psychotic manifestations. To all intents and purposes she had recovered and was officially listed as such. During the phase of polarization, however, she informed the writer in the course of an ordinary conversation that there never had been anything wrong with her and that she should never have been entered in the hospital. Ordinarily such an attitude could be determined only by probing and it is of the utmost importance in estimating recovery or improvement. In this case a fortunate spontaneous statement helped in revising a previous estimate that had been erroneous. Before the statement she was deemed recovered. After it, her status became 'much improved.' This seems to be a minor difference but it is just such differences which lead to an attitude of disbelief in psychiatric statistics. Universal criteria and a means of establishing them are sorely needed in psychiatry, especially when the question of prognosis is considered.

Conclusions

1. In this hospital only relatively few cases (38 to 49) are admitted each year presenting a favorable outlook as we know it at present for hypoglycemic therapy.

2. With present methods, cases with a duration of less than six months show 50 per cent improvement and 22 per cent recovery. Cases with a duration of from 6 to 18 months show 38 per cent improvement and no recoveries. Cases with a duration of over 18 months show 23 per cent improvement and no recoveries.

3. These results are roughly parallel but only one-half as satisfactory as those reported from hypoglycemic therapy, as far as percentage of improvements is concerned.

4. The recovery rate for hypoglycemic therapy is far above that for other methods, but under the conditions imposed it is exceptionally difficult to reach accurate conclusions as to "recovery."

REFERENCES

1. Kraepelin, E.: Dementia Præcox and Paraphrenia. Trans. by R. M. Barclay. Edit. by G. M. Robertson. E. S. Livingstone, Edinburgh, 1919, p. 181.
2. Ibid.: pp. 185-6.
3. Ibid.: p. 188.
4. Strecker, E. A., and Willey, G. F.: An analysis of recoverable dementia præcox reactions. Am. Jour. Psychiat., 3:4, pp. 593-677, April, 1924.
5. Strecker, E. A., and Willey, G. F.: Prognosis in Schizophrenia. Proc. Ass'n. Research Nerv. and Ment. Dis., Vol. 5. Schizophrenia. 1925. Paul Hoeber, Inc., New York, pp. 403-431.
6. Sullivan, H. S.: The Relation of Onset to Outcome in Schizophrenia. Proc. Ass'n. Research Nerv. and Ment. Dis., Vol. 10. Schizophrenia. 1929. Paul Hoeber, Inc., New York.
7. Hinsie, L.: Criticism of Treatment and Recovery in Schizophrenia. Proc. Ass'n. Research Nerv. and Ment. Dis., Vol. 10. Schizophrenia. 1929. Paul Hoeber, Inc., New York.
8. Bellinger, C. H.: Prognosis in schizophrenia—catatonic form. PSYCHIAT. QUART., 6:3, pp. 475-487. July, 1932.
9. Lewis, N. D. C., and Blanchard, E.: Clinical findings in recovered cases of schizophrenia. Am. Jour. Psychiat., 11:3, pp. 481-492. Nov., 1931.
10. Glueck, B.: The hypoglycemic state in the treatment of schizophrenia. J. A. M. A., 107:18, pp. 1029-32. Sept. 26, 1936.
11. Glueck, B.: The induced hypoglycemic state in the treatment of the psychoses. N. Y. State Jour. of Med., 36:20, pp. 1473-1484. Oct. 15, 1936.
12. Paris Letter: J. A. M. A., 108:11, p. 896. March 13, 1937.

PSYCHIATRIC AND SOCIAL TREATMENT

Functions and Correlations

BY LEONA M. HAMBRECHT,
CHIEF PSYCHIATRIC SOCIAL WORKER, NEW YORK STATE PSYCHIATRIC INSTITUTE AND HOSPITAL, NEW YORK, N. Y.

General Concepts

It is with some sense of reserve that one attempts to describe psychiatric social work. The many psychiatric clinics and hospital centers throughout the country, with their varied purposes and facilities, necessarily have given rise to diversification or emphasis of certain phases of psychiatric social work.

There are those centers, organized chiefly for purposes of consultation, recommendation and disposition of patients, where intake and turnover are rapid and extensive and where treatment, quite rightly, is not within the scope of the setting. There are those vast state hospital units where patients are many and distance from their relatives is so great, that repeated contacts with family, either by doctor or social worker, are impossible. There are those monthly, bimonthly or weekly clinics, attempting to serve large rural or urban populations, where hordes of applications wait and limited time for treatment spells for psychiatrist and social worker so significant a problem. There are those too few clinics and hospitals, often privately endowed and many of which have vanished during the recent economic depression, where intake has been selective for the purpose of giving time to development of careful research on treatment methods. Social agencies, courts, and community health centers are now incorporating psychiatrists for consultation or treatment of their clients, many so greatly in need of psychiatric help and yet for whom no psychiatric facilities are available. Then, there are those psychiatrists in private practice who have found need for including the psychiatric social worker in their setup.

Without attempting to enumerate purposes or variety of psychiatric facilities already established, it is self-evident that psychiatric clinics, hospitals and practitioners are attempting to meet

some crying need of their community with the best adaptation possible. These very differences of purpose and function, however, likewise modify, define, limit, develop or accentuate the type or scope of psychiatric social work incorporated with each setting. History-taking, social treatment confined to first interviews and transferrals with recommendations to community agencies and hospitals, defines the bulk of psychiatric case work possible to certain settings. Other psychiatric social workers, with opportunity to carry on long time social treatment or to follow a case from its beginning to the close of its psychiatric treatment, are barely recognizable as utilizing the same variety of skills. And, of course, there is every intermediate shading of these two extremes in function.

The psychiatric social worker is now recognized as an essential adjunct to clinic and hospital treatment of psychiatric patients. It is presumed that the worker has had specialized professional training. This implies graduation from a school of social work of recognized standing, and at the least, an interneship of practical experience as a social worker in a psychiatric center.

There has been much confusion regarding differences as well as similarities between the work of the psychiatrist and that of the psychiatric social worker. Since an early, uncategorical beginning, the social worker has been wreathed with the conception of a doer —one whose efforts are bent in rearranging the environment of a client so that he may live more usefully and happily. The psychiatrist has always been recognized as the individual's therapist, who upon treating the patient, calls for the social worker's help in carrying through an environmental program suitable to the patient's psychiatric needs. The above seems a simple and easily grasped demarcation and one that should offer no confusion. Upon undertaking these separate measures, however, both psychiatrist and social worker early found that a shift of material surroundings for the patient in combination with his treatment, was usually not enough. The patient's environment always presented those human elements of attitude, behavior and prejudice. The questions would arise, "What *is* the patient's environment?" "How can we recondition environment, including family, to meet the patient's needs?" "What unhealthy factors in the patient's environment prompted

his sickness?" "Who is there, besides the overburdened psychiatrist, to undertake treatment of these factors?"

The psychiatric social worker is called upon not only to find new avenues of employment, recreation, education and improved living conditions recommended for the patient, but to help those people surrounding the patient to understand and accept these needs: the mother should let the patient take more responsibility; the father must not object to the patient's wider social life; the parents must relinquish their cherished goal that this patient go through college; the father should find a job and earn enough to afford a cheerier apartment in a better neighborhood; the argumentative parents should at least avoid carrying on their quarrels before the children; the mother must not confront patient before his friends, with her endearing terms, "Sweetie-pie" and "Angel-face," if he is to get well. These and thousands of similar or more subtle situations confront the worker who attempts to cope with the patient's environment.

To the lay person, unfamiliar with the profundity of such expressions of attitude and behavior, it seems still to be a simple matter to caution or advise. But the psychiatrist, appreciating the deeper roots from which such expressions spring, has contributed his experience and thinking to the social worker's endeavors, to help toward making her more proficient in the process of obtaining the desired result. Today, after nearly two decades of mental hygiene in schools of social work, combined with knowledge gained from the practical efforts of psychiatrist and social worker on single casework problems, the following have become accepted facts: (1) that far-reaching and permanent gains from social casework as from psychiatry, can accrue only when those individuals treated recognize a problem and wish change; and (2) that social treatment cannot be relegated to the patient alone but includes those who intimately surround and contribute to the patient's life. Thus, all psychiatric social work, like psychiatry, must concern itself with individual attitudes to achieve an end, which end in itself, may seem simple enough.

The purpose of this paper is to describe the functions of psychiatric social work in a purely psychiatric or clinical setting,

aimed to carry through psychiatric treatment; to differentiate the work of the psychiatric social worker from that of the psychiatrist; and to illustrate certain types and techniques of social treatment which have been adapted to a total situation. This résumé of function, method and adaptation is based upon research and treatment experience of the New York State Psychiatric Institute and Hospital. Because this setting includes both hospital and outpatient service treating both children and adults, it renders a cross-section of most kinds of cases considered for psychiatric treatment. Dependent upon the background and needs of the patient and his family and the psychiatric facilities available, psychiatric social work should offer every flexibility, avoiding fixed ideas regarding approach and technique. Those processes herein described must be understood as representative of general experience, thinking and philosophy adopted by the above center.

Administrative Function

In any psychiatric center, the direction and responsibility for treatment devolves upon the psychiatrist in charge of the service to which the patient comes for treatment. Social service, like all other departments, becomes an adjunct or aide to psychiatric service in such a setting. The psychiatrist, for this reason, must take the responsibility for admission and discharge or parole of a patient. Social service can be of valuable assistance to the psychiatrist, however, in carrying through satisfactory decisions upon points concerning intake, treatment and discharge, and the psychiatrist usually grows to expect such aid. This is not only because of the social worker's knowledge of community resources and referring agencies for a particular locale, but also because the social worker is presumably acquainted with the family situation of the patient and can best gauge the amount of stability in the family setting in terms of carrying through treatment recommendations or plans.

The need on the part of the psychiatric center to educate the public in the use of the clinic or hospital is a primary function. Social service departments have become increasingly helpful in their contacts with the public through schools, social agencies, com-

munity centers and citizens at large, to clarify policies of intake and to make generally clear, especially where intake is selective, the types of mental problems or behavior difficulties acceptable for treatment. Often, by preliminary discussion of their patient, referring agencies or individuals are helped to prepare the patient's emotional acceptance of referral. Agencies may also be helped to present their accumulation of data about the patient in a form, historical or otherwise, most readily acceptable to the intake process. When a case described for referral is recognizably unsuitable for the psychiatric center, guidance of a referring agency to another treatment source, thus avoiding for the patient unnecessary delay and resultant rejection for treatment, may become another function of the social service department.

In like manner, social service becomes the connecting link between the treatment center and the outside in clarifying or interpreting the patient's condition with psychiatric expectations and recommendations on his discharge, in planning a social program, and in working with the lay public's attitude of fear or suspicion about a person who has had a mental illness. The rapidity and ease of accomplishing such general education of referring sources and sources to which treated patients may be referred, depends largely upon the consistency, reliability and social-mindedness of the treatment center and the care taken in interpreting the patient's condition.

Correlation of Service

Within the treatment sphere, the close correlation between psychiatric and social service is of vital importance. Not only does each have a growing contribution to make to the other, but treatment plans must progress with a unification of aim in consideration also of treatment time necessary. The immediate or early referral of a case to social service is of primary importance when the psychiatrist expects social treatment. The patient's acceptance and understanding of the social worker's function is likewise eased by her early entrance. Even in as routine a matter as the referral of a case by a psychiatrist to social service for specific help—recreational facilities, employment, camp placement—the social worker

should ascertain first-hand some of the patient's previous social experiences in order to guide him to those resources which may offer him the most suitable help. Thus, although the social worker's regular contact with the patient himself, such as consideration of his employment, may come last in treatment, yet her initial study of the patient's social situation should have been made early in the course of the patient's psychiatric treatment. An outstanding exception to this procedure may exist, however, in the case of adult outpatients who seek psychiatric treatment often unknown to their families and who continue to make a community adjustment.

For intensive work with the family situation (and in many cases, the family is as symptomatic of pathology as the patient) social service should, *a priori,* have opportunity to begin contact with the family at the start of the patient's treatment. This not only brings to the psychiatrist a better picture of the reality of the patient's problem, but also allows the same amount of time to attempt reconstruction of the family's understanding of the patient, if these results are expected.

Such correlation between psychiatrist and social worker demands their close-working relationship, their interchange of records and frequent conferences. Presentation of cases before a conference staff including other departmental psychiatrists and social workers, during the treatment period, is of inestimable value in gaining a consensus of opinion in psychodynamic thinking and plan for treatment.

Formal history-taking is not undertaken as a routine duty of the social service department in the setting to which this study refers. Because of the medical and psychiatric emphasis, a formal history is considered necessary by the psychiatric staff and is taken as a routine, usually by the psychiatrist treating the case. This serves not only the cathartic advantage ascribed to histories in terms of patient and family as well as an early framework of knowledge upon which psychiatric treatment may be based, but also, an opportunity for the psychiatrist to acquaint himself with the patient's relatives. The social worker is thus free to undertake a less directive contact with a family which is more than likely to require such an approach. A double advantage is likewise achieved, since

a close relative too mentally sick for intensive social treatment may be early recognized by the psychiatrist and the family situation handled with this knowledge.

It is believed at the institute, however, that all psychiatric social workers in the department should have the trained ability for, and occasionally should experience, the process of formal history-taking to amplify their variety of skills or for particular treatment purposes. Whether the psychiatrist or the worker takes the original history, no genuine difficulty has been met in the worker's subsequent treatment relationship to family members, providing her function and continuous participation has been explained, which may well be initiated by the psychiatrist at the intake interview.

Recognized as complementary rather than supplementary to the original history, however, is the social worker's more detailed social study.

The Social Study

The social study begins with the worker's first contact with the patient or family, unless she has been asked to take the history. Its aim is to secure a composite picture of the patient's emotional environment and factors surrounding the development of the patient's problem. This is done through a series of interviews with the key persons in the family, usually the parents or mate, together with the information obtained from school, social agency or work record, when indicated. From the first contact, a potential treatment relationship has begun and the amount of benefit or insight gained by the person interviewed, through reciprocal consideration of the patient's problem and experiences contributing to it, implies a gradual review of the total family structure.

The approach should be stressed, in that the informant comes at first with the understanding that he is participating in a mutual study of the patient's problem. No commitment on the part of the worker is made during this preliminary process that defined help will be given, except that as the informant discusses details of the patient's life and those persons involved, he may reach a better understanding of the problem. As the worker indirectly points the interview to a discussion of feelings pervading the patient and fam-

ily members, the interviewee*, for example, the focal person, is gradually led to see his need for help with his part in the problem and the study may develop into a treatment relationship.

Since a preliminary anamnesis has been secured, little emphasis is placed on the factual data obtained through the social study, although it is carefully observed and added to the general fund of information. By means of this gradual and less directive approach, the chief contribution from the standpoint of information gained, lies in a more veritable picture of the family's emotional content. There are apt to be great discrepancies between anamnestic data obtained and that gained from the social study, especially in the realm of feeling, and in the expression of hostile feelings toward patient and in disclosure of marital discord.

For example, in the case of a three-year-old girl, referred as a feeding problem, the mother stated, at the time of the anamnesis, that she and the father were compatible and that favoritism had never been shown either the patient or her sibling. Early in the social study, the mother complained of marital incompatibility and her disgust with her husband, and also that she had openly spoken of the patient as her "hate child" and of the sibling as her "love child" and that she had always treated them as such.

During the process of social study, acute situations such as gross financial need, family sickness, extreme symptomatic reactions on the part of the clinic patient, etc., must be met and handled as they inject themselves, to relieve informant's tension and allow relaxation for discussion of underlying problems.

By means of the social study, a much clearer picture of the personality and reactions of various members of the family should have been acquired and observed. Certain inquiries or remarks on the part of the worker should enable her to judge with some accuracy the type of treatment most acceptable to the person interviewed as well as the treatment most applicable in terms of the total situation.

Need for discussing the material secured with the psychiatrist treating the patient, cannot be stressed too strongly. The worker

*Interviewee, informant, focal person, etc., are terms frequently used in this paper to dsignate the patient's relative; whether father, mother, sibling, mate, etc., with whom the interview is held, and usually implies the person upon whom social treatment is focused.

is thus aided in her understanding of the personalities with whom she deals and also may better correlate her work with the psychiatric treatment. Concurrently, the psychiatrist's knowledge of the emotional interplay surrounding the patient is enriched. By such analysis, the psychiatrist and worker are enabled to determine, at least tentatively, the ultimate goal, the type of treatment, social treatment focus, and the basis for cooperation in treatment between worker and psychiatrist.

The social study thus serves: first, as an exploratory process for study of the total family constellation from standpoint of economic, social and emotional structure; second, as a means for interviewee's release of feeling; and third, to offer the opportunity on the part of both worker and family member interviewed, to participate in the development of a treatment relationship.

Social Treatment

A plan of social treatment, dependent upon the picture gained and the progress of the patient, should follow the social study. It may mean social treatment aimed only to help the parents or family accept a plan of disposition of the patient who is too mentally sick or whose family is too unstable to assure the patient's reasonable adjustment in the home. Hopefully, it is a plan of treatment to recondition family and patient for his living within the home. It should be needless to add that all social treatment entails the worker's knowledge and use of community agencies and resources for patient and family when indicated, such as clubs; athletic, handicraft and recreational centers; nursery schools; home and boarding school placement facilities; health centers; camps; means of financial relief, etc. Such community resources are not an end in themselves, but offer the means to formulation of a psychiatric program. To enable the patient or his family to make constructive use of such resources, becomes the psychiatric social worker's task.

Methods or techniques of social treatment dealing with familial, emotional relationships, must be based upon the informant's ability to express his problem in terms of his social relationships. This excludes individual, social treatment of parents or family

members who are definitely psychotic or who express vague symbolic symptomatology unrelated to their reality situation. Approach here is classified for convenience into three large categories, namely: (1) supportive therapy; (2) suggestive and interpretive therapy; and (3) direct treatment of attitudes.

In surveying most cases, it is found that a combination of the first two of these methods is used but that the emphasis varies, usually in relation to the progress of the case and the degree of pathology present. To generalize, the type of treatment suitable depends upon the total pathology of the social and emotional home structure and the amount of insight shown by the family member or members upon whom treatment is focussed. Insight, in this instance, involves the individual's acceptance of treatment for the problem as he sees it, and his ability to recognize to some degree his own as well as others' contribution to the problem.

Supportive Therapy

(1) Supportive therapy indicates primarily a "listening" approach by which the informant, after the worker's explanation of her function and service, discusses the problem for which treatment is sought. It is called "supportive" in that the worker makes no attempt to modify by statement or interpretation, the viewpoint or attitude expressed by the interviewee.

Supportive therapy has been found the most advantageous first approach to all social treatment situations. It is used for establishing the empathy between worker and family member, necessary to evolve the social study. Its first aim is to make possible the interviewee's release of feeling, which perhaps is the most important contribution in psychiatric social treatment. Its second aim is to point the interviewee's pattern, but only by the worker's restatement of the essential feeling-tone or relationship impinging upon the episode related, and not by direct interpretation.

The method involves the worker's frequent use of an impartial, sympathetic rejoinder such as, "It was difficult for you," "This disturbs you," "It was natural for you to feel that way," etc. By such generalizations, leading to further discussion, the worker's sympathetic and uncritical understanding of the interviewee's feel-

ings is conveyed and the problem is immediately pointed to involve interviewee. In the course of the informant's elaboration of the patient's problem or family relationships entailing emotional reactions, more specific comments are made which gradually reflect the informant's pattern, shifting the emphasis from that of sheer complaint.

One mother contrasted her overanxiety to the father's indifference in handling the patient and the worker took casual opportunity to say, "You feel differently about him than his father does." Again when she detailed father's sexual demands and her repugnance, the worker interpolated, "You do not feel as your husband does about sex." Later, elaborating her many instances of dominating the home, both in regard to episodes of her early life and the present, it was commented, "You could trust no one else to take the same responsibility," "You felt most satisfied when you managed the situation alone," etc.

No attempt is made here to point a new rôle for the informant to play nor to add a variation to the type of thinking, feeling, or philosophy which the informant presents. The comments of the worker as above indicated stimulate the informant's further uncovering of feeling in terms of specific episodes and give opportunity for the informant to see and emphasize more clearly his part in the family picture. This lays the groundwork for further insight.

At times, description of specific episodes or detail is obtained by asking for an instance or for elaboration when interviewee makes a general statement. Hidden guilt or defense reactions, when specific instances are given, may be brought to the surface by a skilled worker by means of such comments as, "You blamed yourself," "You dreaded the consequences," etc., when the material given clearly conveys such feeling. Such opportunities when used skillfully permit the informant to share and elaborate upon feelings otherwise repressed and for which the informant has built a rationale of anxious defense.

For example, a mother in detailing her pregnancies, gave instances of many attempted abortions and recklessness of her health when pregnant, expressing as her reasons, her disgust with doc-

tors and her dislike of supine prenatalism. The worker, sensing that the mother had many more immediate reasons for dismissing her duties as wife and mother, expressed for her the fact that she dreaded pregnancy and had conflict over childbearing. The worker had said nothing new since the mother had been elaborating upon these points, but in formulating the statement in terms of feeling —dread and conflict—the mother's emotions of guilt and grief over pregnancy were expressed with real force in terms of her husband and her child.

Such openings for an informant's elaboration of feeling are of greatest value so long as the worker does not add color or a new interpretation to the material already uncovered. The worker does aim to crystallize the feeling already expressed, which the informant may freely choose either to reject or accept in terms of further explanation and elaboration of feeling.

Supportive therapy thus gives opportunity for release of feeling and aims to point out indirectly to the individual interviewed, his pattern of reaction. It often develops into the form of a confessional regarding repressed feelings which, heretofore, the informant has not wished to recognize or admit. Reassurance is a tool of supportive therapy in that the worker helps the informant to face and accept his feelings in view of the difficulties which he has met and the reasons or philosophy which he believes motivate his action. Such reassurance is given also on the grounds of material covered: "You did not understand," "You were perplexed," and not by worker's finding further reasons or explanations. Reassurance of other types, such as approval expressed by worker for wise procedure, encouragement to carry through a plan, review of progress made, etc., is incorporated under the more active type of suggestive and interpretive therapy, an approach which combines with supportive therapy as casework progresses.

The basis for the treatment relationship in supportive therapy comes from the empathy established between the worker and informant due to the worker's immediate attempts to identify with the informant's feeling reactions and the informant's growing identification with the worker through the latter's re-expression of informant's disclosed feeling. Supportive treatment is not pushed

or forced but follows the informant's own tempo, which serves as a safeguard in touching upon areas of feeling extremely painful or distasteful to the interviewee.

After the social study, supportive therapy is chiefly used throughout treatment of a casework problem when the informant is depressed, self-deprecatory, or neurotic in a compulsive or anxious form and when guilt seems to be the strong underlying feeling component. Because of its noninterpretive element, supportive therapy is especially indicated with parents who are, themselves, emotionally disturbed or when the patient is too mentally sick to predict a favorable outcome. In the latter instance, a treatment plan involving the patient's final disposition for continued treatment care, away from the home, demands the introduction of a more interpretive and directive approach with the parents. Such interpretation is used chiefly to explain the patient's needs as a sick person and avoids clarification of the parents' part in the problem, which under such circumstances, might only uncover unequivocated feelings of guilt.

After release of feeling has thus been accomplished through supportive therapy, the interviewee usually proceeds quite naturally to next steps in treatment. Such are indicated by his lessened anxiety and emotion concerning the problem or because he expresses insight either in discussing (1) himself as the problem, (2) causes for the problem for which he now shows better understanding, or (3) concrete plans of his own invention by which he can decrease the patient's difficulty.

When the person interviewed expresses a desire for further treatment for himself, a decision must be made at the psychiatric center, whether the interviewee shall be carried by a psychiatrist or a social worker. The basis for deciding treatability and the choice of a therapist depends largely upon how the person interviewed expresses his problem, namely, in terms of his social relationships and attitudes, or by means of symptomatic fears, vague pains, suspicions, doubts, unidentified feelings, etc. The social worker usually continues with those parents or family members who are making a concrete attempt to meet their reality situations. The other type of symptomatology described is early recognized as a result

of the social study and is handled by a psychiatrist, or a treatment relationship is advisedly not developed.

In the case of one compulsive neurotic mother whose child had been a patient in the institute because of a feeding and vomiting problem, the mother insisted upon trying the child at home believing the child cured by treatment and having expressed no awareness of her part in the problem. She had received only prescriptive advice during the child's hospitalization. After a year's struggle with the child at home, during which many of the mother's defenses regarding her hostility to the child were released through supportive treatment, she concluded that she was the problem and that she could no longer live successfully with the child who presented no symptoms except with her. In this case an extremely disturbed and resistive mother had come to propose a plan now emotionally acceptable to her for the child's living apart from her, and also asked for treatment for herself in terms of her social problems. It was decided in view of her acquired insight, to allow her to continue social treatment for herself with the child placed in a boarding school, according to the plan which she had been able to formulate.

In another case where much the same problem presented itself although the severity of the child's problem was less marked, the mother's anxieties and complaints lessened, through supportive treatment, to the point where she was discussing, freely, methods of handling the child and undertaking to learn and to interpret causes for the child's behavior. In view of her objective attitudes, her observed happiness expressed in successful outcome of new methods tried with the child and her absence of complaint and anxiety, suggestive and interpretive therapy was incorporated without further need of elaboration in the realm of the mother's personal feelings except as they touched upon the acute problem.

Suggestive and Interpretive Therapy

(2) Suggestive and interpretive therapy bears out what its title implies, namely, that by means of interpretation and suggestion, the interviewee's better understanding of the patient's behavior is arrived at or an acute need is met. This does not imply

a rhetorical approach, nor should it include interpretation more complex than can be accepted by the interviewee in view of the data and feeling relationships already uncovered by him through the social study. Such a method can be used as the chief means of therapy only when the interviewee is able to identify to some degree with the patient, and when by reciprocal discussion with the worker, he shows ability to recognize causative factors and relate them to the problem presented.

For example, one mother remarked, after a period of supportive treatment, that the patient was jealous of her brother. The worker attempted to clarify and establish this discovery made by the mother on the basis of interpretation which the mother could accept and use. The worker requested instances on which the mother based her conclusion, thus endeavoring to help her reason why such a situation might exist. The mother gave instances of the patient's jealousy and alined this, with worker's suggestion, to patient's long period of babyhood and mother's treatment of her as a baby, these experiences having been previously related and accepted by mother as factors contributing to the patient's problem. The worker then recapitulated the problem, namely, that patient was jealous and demanded, mother supplied the word, "attention," and worker added, "from mother." Mother nodded enthusiastically. Worker then inquired from mother how patient could receive the expected attention in such a way that she can be helped to overcome her babyish dependence upon mother and yet not feel jealous of brother. Mother did not know. After directed discussion of her treatment of brother, whom she had encouraged in doing things for himself, worker pointed out that she gave him attention in a different way. Mother had not realized the difference in her treatment of each child but now suggested that it would be better not to "holler" at patient so much, nor do so many things for patient but to praise patient as she does brother, for what patient does for herself. Worker suggested, in attempting to reflect the mother's feeling, that mother had felt patient so dependent a child that she had almost had to spoonfeed her. Mother jumped eagerly at this suggestion, asking, "How did you guess it?"

In the above, the worker does not merely ask for elaboration of feeling in terms of instances but uses instances given, by means of a reeducative process to point further reasoning, generalizations and conclusions, in which to be effective the mother must participate. At times the worker's interpretation does not follow exactly the material given by the mother, but adds new thinking as in appealing to the mother's logic for a new method or as in the suggestion regarding spoonfeeding, which breaks the way for the mother's further admission regarding her handling. The latter is done without the element of accusing the mother of false handling, but by paralleling her dilemma to some generalization.

Successful outcome by means of suggestive and interpretive therapy implies that the interviewee sought treatment for the problem, came to recognize his own mishandling of the patient, sought with some objectivity to understand and to learn, could identify with others in the family picture, and when suggestive therapy had begun, there was no apparent intense hostility or rejection directed toward the patient in the area where the problem focussed.

In such case work situations as these, where suggestive and interpretive therapy becomes an acceptable medium for handling the problem recognized by the interviewee, supportive therapy frequently continues concurrently when touching upon those areas of emotional experience in which the interviewee shows disturbed feelings. For example, one mother well past the complaint and anxiety stage concerning the patient, was entering freely into suggestive and interpretive treatment regarding the patient's problem, but when discussing other areas where her emotions were deeply involved, including her husband and her relationship to her mother, supportive therapy was used. In this way a parent's own emotional problems may be frequently met and indirectly handled during the treatment of the patient's problem, for which latter reason the parent believes himself participating in social treatment.

Advice and Recommendation

There are situations, however, when the patient's problem does not involve recognizably severe emotional attitudes on the part of other family members; or when family members are self-satisfied

enough that, although exposed to supportive treatment through the process of social study, they neither seek further understanding of the patient nor of themselves; or when familial attitudes are of such emotional intensity and pattern that social treatment is inadvisable. Without entailing further description of such situations in this paper, it should be pointed out that a treatment relationship to gain emotional acceptance and understanding of the patient's problem and needs is not established. A purely educational approach is here used, which is directive, rhetorical and intellectualized in quality. This is handled either by the psychiatrist or by the worker or both, usually dependent upon previous contacts. Results of psychiatric study of the patient are explained in a direct way, the patient's needs of certain emotional attitudes in the home are interpreted and recommendations for further treatment or handling are advised. Universalizing the problem of the patient or the family situation is often a means of presenting this type of advice. Given purely as advice, changes in attitude are seldom if ever expected, and in some situations, unnecessary, but often some difference in the family's handling of the superficial or acute problem is achieved.

This method is not therapeutic in its value to the family and is not termed as such. It often consists of no more than one or two interviews. It is also frequently used by the social worker in discussing the patient with members of the family less involved and more reasonable about the patient's problem than the family member on whom treatment is focussed.

Direct Treatment of Attitudes

(3) Direct treatment of attitudes* demands a focus upon the family member who, through supportive therapy, comes to appreciate need of treatment for himself. Here the worker assumes the rôle of therapist to the interviewee who no longer focusses or projects the problem away from himself. The therapist-patient relationship marks the primary distinction in this treatment, in that the family member upon whom social treatment is focussed, comes to the interview with the clear understanding that he expects help

*Similar to attitude therapy originated and developed by Dr. David M. Levy in collaboration with psychiatric social workers of the Institute for Child Guidance, New York City.

from the worker for problems which he recognizes in his own social and emotional adjustment. Under these conditions, treatment expectations are more far-reaching, since the type of material discussed by the interviewee focusses upon his own life experiences which are directly expressed and met by the worker, rather than being adjacent, indirectly handled and recognized only as coincidental to the patient's problem.

As a condition to this treatment, the interviewee must readily verbalize in terms of his social situations and see his difficulty as involving his feelings, attitudes and behavior. To profit by such help from a social worker, the interviewee is not psychotic; nor does he talk in morbid or symbolic similes, nor express his problem as some vague physical or mental difficulty which can be readily classified as an advanced neurosis or other medically recognizable syndrome. This removes the possibility of the social worker's attempt to deal singly and therapeutically with those mental and emotional problems which enter into the psychiatric field.

Other considerations for treatment selection are the recipient's age, the rigidity of his personality, the amount of dissatisfaction he suffers in view of his present adjustment and the probable results, regarding other family members and himself, in view of his change. Most of the persons so treated are not past middle life, so that they may be capable of readapting themselves to a not inflexible life situation in view of insight gained. The consideration also of treating the parent of an irrecoverable patient should be weighed in view of how much the parent suffers from a sense of self-recrimination regarding the patient's illness. Some parents lacking deep understanding are apt to condemn themselves for the patient's condition and are benefited by treatment which removes the focus of feeling from this area. Others, unaware or even partially aware of their destructive effect in relation to the patient, could not healthfully face added insight.

All of these considerations combine to place selection for such treatment upon the basis of relatively mild personality deviations and such selectivity requires the safeguard of a psychiatrist's diagnostic opinion.

Safeguards for the process of the social worker's direct treatment of attitudes depend upon: (a) the setting; namely, that such treatment be carried in a psychiatric center where a psychiatrist may be consulted for clarification of diagnosis and for continued advice and guidance or may, if necessary, take responsibility for treatment, (b) the method; the social worker makes use of no dream material nor free association methods nor those psychoanalytic techniques which aim directly, to uncover the field of the unconscious; and (c) the interpretations; *based chiefly upon the method followed in supportive therapy.* The interviewee is led to recall his life experiences in terms of the people surrounding him and his feeling responses to them, the worker re-expressing for him the feeling tone which the experience carried and, by question or comment, helping him to relate these to similar reactions which he has previously specified, by given instances, during the course of treatment.

For example (quoting from a case record in which the mother's unsatisfying relationship with her child and husband were overcome) the mother's expression of her problem at first centered around the frustrations felt by herself in the control of her child, Joslyn. She soon told of her earlier frustrations with her dominating sisters and stepmother. Only the statements in parentheses are the worker's:

> Mother is most troubled by realization of her desire to have Joslyn out of the way. That was never so tangible a feeling before. Sees she is creating in Joslyn what her stepmother did to her yet feels worse that all this has fallen on Joslyn. She never had wanted her but used to feel some restraint. (You are afraid of losing control of your own feelings.) Afraid almost to be alone with her; does not know what terrible thing will happen, "Do I convey to you all that I am cramped with?" Last few times she was here, she felt more relief than ever, yet cannot feel better about Joslyn. (You see in Joslyn what you felt inimical in others—sister, Laura, stepmother, etc. It is natural to want to push Joslyn out. The stronger this feeling of thwarting by other females becomes, the greater the desire to destroy Joslyn who again thwarts you.) It gets mother into a terrible state where she could do awful things. (What?) Could strangle her. Mother feels like a bear ready to pounce on her when she shows off.

Later in treatment, as the mother has told of sister Laura's early protection of her (mother) concurrent with Laura's hostile domination of her as a child, mother asks:

> "What is in me that I could not rebel?" (You saw Laura as a protector and enemy and your dependency made it harder to fight in spite of your hostility.) Mother suspects this is so even now. Perhaps it was natural for Laura to want to dictate when mother clung to her for help.

The interviewee is free to accept or reject the worker's interpretation which is given as a possible similarity of situation and provides opportunity for informant's further elaboration and association of feeling. From this type of association, the interviewee drains intense, often hostile and originally unidentified emotion; he gradually points his pattern of aggression, martyrdom, competitive rivalry, etc., and interprets causes for his attitudes. One aim of direct treatment of attitudes is to disseminate intense feeling surrounding an acute situation, such as the patient's problem, by encouraging active expression of present feeling, and recall of past relationships likewise with association of feeling. As the person interviewed describes his life experiences, not alone in terms of narrative but with attendant feeling, he gradually becomes absorbed in recognizing his own strength of attitude and reaction, under like circumstances. The informant's association and recognition of identity of his emotional reactions is speeded by the worker's comments only as those feeling tones become clear, during the course of treatment. This mutual recognition and acceptance of the interviewee's pattern of feeling and causes for such, establishes the final aim of treatment, namely, the informant's objective self-understanding.

Such direct treatment, need not, necessarily, run the entire gamut of the interviewee's recalled life. Sometimes only particular areas need be treated in this way to gain great relief for the client. In one instance, a mother, deserted by her husband for five years, continued to count on his return and to make no plan for herself or children. She resisted applying for help from relief agencies although she helplessly sought material aid from friends and relatives. It was not until her earlier relationship to her sisters and

her jealousy and punishing dependence on them was emotionally related by her, as well as that her expectations from her husband correlated with her idealism of her father, that she declared her realization and fear of her dependence and her total lack of self-confidence. Following such clarification, her hostility for her husband was expressed. Her sense of his rejection of her linked with her feelings of rejection by her sisters to whom she vacillatingly clung subjecting herself to further rejection, thus punishing them and herself. When she had discussed the above through several interviews, concluding herself emotionally dependent, and saw herself counting upon a man from whom she knew aid would never be forthcoming, she determined to free herself from her dependent rôle. She was able to overcome her feeling of grief and loss regarding her husband for whom her expression of hostility seemed to erase the ideal she had imagined him. She is now successfully supporting herself and children, looking forward to final divorce papers with an ultimate hope for future remarriage. Following the above direct treatment which totalled a period of six months, this mother has been stable, happy and independent enough to consider her personal problem solved.

In other instances, a longer period of time is necessary to disclose enough personal experience for the interviewee to recognize and relate origins of feeling and behavior. Such treatment implies not only a better self-understanding, through processes detailed, but also a readjustment in behavior as well as in feeling and demands the supportive treatment necessary to cover such a period of readjustment.

One mother, during the course of treatment, undertook to express her new found self-assertion by refurnishing her home, a desire long nourished yet unfulfilled, due to her fear and insecurity regarding her husband, who, she claimed, saved his money to give to his relatives. Through this activity on her part, she was able to achieve a new and more companionable relationship with her husband, although his first reaction was surprise and resistance to her "poor judgment." Through her expression of feeling to the worker regarding herself and her husband during the process of this experience, she became able to handle calmly her relationship

with him and for the first time, to articulate to him her feelings as well as the reasoning behind her plans which developed a stronger bond between them and a warmer response in him. However, her crystallization of thinking, feeling and planning was achieved by her free expression of feeling during the treatment interview in an attempt to understand her husband as well as herself and undoubtedly by an identity with the worker. Had she been dismissed from treatment at the time that this activity flourished, her change of behavior could have caused disastrous consequences in her marital relationship because of her still untried self-expression and her inability then to cope with her husband's unchanged pattern of reaction.

From the foregoing description of social treatment it should be clear that direct treatment of attitudes is a method used when all other social casework methods have been tried and have failed. This does not indicate that direct treatment in itself may require more skill. The successful use of indirect methods implies the social worker's cognizance and resourceful application of all her scientific knowledge and casework performance in that area. The ability to treat a casework problem successfully, without incorporating direct therapeutic measures is therefore indicative of a fine discriminating evaluation and the use of trained techniques throughout the casework process. The ability to carry through direct treatment to a successful conclusion, demands a psychiatrically trained and experienced worker with a new quality of skill, namely, a personality makeup adaptable for establishing and analyzing therapeutic relationship, not only in regard to the client but more finely in regard to herself. The fact that this latter form of casework closely resembles psychotherapy and that its implications are deeper and more far-reaching in terms of the client, demarcates direct treatment as a more serious undertaking. With such, the psychiatrist places the trust of his techniques within the social worker's scope, expectant that she will undertake such treatment cautiously and discriminatingly and resort to its use only in those situations where it is applicable.

General Discussion of Approach

To summarize here, the outstanding features of social therapy techniques aimed toward modification of attitudes, as described, may help to clarify the past discussion of approach. Because of the worker's aim to serve as a medium by which that person interviewed may release feeling, articulation of the crux of the problem remains with the interviewee. That the subject of discussion remains the choice of the interviewee, in view of the worker's explanation of her function, points a significant lead in the total understanding of the personality of the informant and the area of his concern. In one instance social treatment may be confined, in view of the protective resistance of the interviewee, to his interpretations of the patient's present and past problem. In another instance, the informant may early discontinue discussion of the patient to discuss himself, usually, at first, in relation to his acute difficulties. This by no means places the relationship on the basis of direct treatment of attitudes unless the informant recognizes that he needs personal treatment for his problems and comes to the worker for such. The worker can help to point the way in the latter instance, if it seems advisable, by calling attention to the fact that the interviewee is disturbed and needs help with this. Before the informant enters into such treatment for himself, however, he sees not only need for help in rectifying an acute situation, but need for treatment of a personality problem which covers a wide range of social adjustment.

The therapeutic results of a supportive approach, whether direct or indirect regarding the personal problems of the person interviewed, depend upon the worker's skill in establishing a relationship in which the informant feels free to express himself and by which he may be led to associate and relate experience, drawing largely upon his own powers to make conclusions. The old question and answer method does not enter to impede progress or to define the interviewee's expectations of treatment. No longer does the informant believe that he comes to answer a number of questions, after which like a medical history and diagnosis, a prescription will be given. No longer does the influence of suspicion and

doubt intervene regarding the question asked, nor is the informant concerned with an attempt to puzzle out why this or that question or topic for discussion was raised. In establishing a contact by which the interviewee realizes from the first that he participates in study of the problem, he develops a growing interest in the mutual discovery of causes for the problem, a discovery which in part becomes his own creation.

The worker's skill again is called into play when she redirects the focus of discussion from the problem in and of itself, to the problem as it concerns the informant. Here, the opportunity to point the informant's pattern and characteristic reaction, crystallizes for him his feeling tone and opens the way for his recognition of the part he plays. By this approach which encourages specific elaboration of episodes and social experiences, the intellectual focus of the interviewee upon feeling as such is avoided. Thus, the prevalent tendency toward intellectual self-analysis, and philosophical generalization is more readily overcome. By helping the informant to relate the episode in terms of his feeling, which the worker reflects by occasional sympathetic comment, "You resented this," "You were irritated," etc., the succession of interviews continue dynamic and valuable to the person interviewed. He comes to avail himself of the opportunity to release his tension—rather than continuing to relate the problem in terms of the patient, until exhausted by repetition and by waiting for that "open seasame" solution which never comes. This shift of emphasis from the patient's problem to the parent's or key person's reaction to the problem, becomes a tension release regarding the acute situation. Whether or not further treatment for the interviewee is deemed advisable, insight is gained in most instances to a rather surprising degree.

Certain questions which arise concerning the process of social treatment when a supportive approach is used, should be clarified. Shifts of focus or simultaneous handling of the attitudes of more than one family member frequently occur, except in the course of direct treatment of attitudes. Here, treatment focus is confined, since the person interviewed comes to the worker, not to discuss the circumstances of the patient's problem but to discuss himself.

Acute difficulties in all ordinary case work situations, where a supportive approach is chiefly used, are met and handled with the interviewee as they arise, usually by a suggestive and interpretive discussion with the informant's participation. This is again distinguished from direct treatment of attitudes where the recipient's discussion of acute difficulties becomes, primarily, his consideration of himself in the meeting of these.

Collaborative Therapy Between Psychiatrist and Social Worker

Children:

More than a proportionate amount of space has been consumed upon the social worker's single treatment of attitudes of family members within the patient's home. There are situations, however, where the psychiatrist and social worker may be working intensively with the same person but with a different motive and approach. In contrast to the usual division of labor between psychiatrist and social worker treating patient and family respectively, there are some cases where the psychiatrist may speed total treatment by assuming a more active part in treatment of the family.

The mother of a boy of 12, his diagnosis, psychoneurosis, compulsive type, was an extremely tense, anxious person who considered the patient's problem the result of her fate. She, at first, could not talk freely even of his acute problem, and spent her time during the interview, elaborating upon the significance of God's punishment for an unknown sin and defending her treatment of the child in relation to any social situation touched upon. She flushed, cracked her knuckles, paced the floor, looked anxiously out of the window for a glimpse of her boy, if at play, and complained of her feelings of depression and inability to think clearly.

It was felt that this parent's problem was the outstanding causative factor of the child's problem, yet the mother herself was incapable, at first, because of her own severe neurosis, to enter into the ordinary social study relationship detailed in this paper. With the psychiatrist's understanding of the patient's problem, recognized by the mother, and his ability to gauge the import of the parent's behavior, he was able directly, although gradually, to interpret the patient's problem to the mother. The worker served, at

first, more as a buffer to whom the mother could express her hostility regarding the physician's interpretation, and who supported the mother in working out the full meaning of the psychiatrist's statement, thus saving the psychiatrist's time. Also, the worker, by her regular contact, continued to build a social treatment relationship with the mother.

A plan was worked out, whereby the mother was seen by the psychiatrist and faced with some part of the patient's problem as it related to her. She was then seen by the worker over a period of several weeks, and allowed to express resentment regarding the physician's statements, finally working through their significance as far as patient and she were concerned. This process was then repeated and so on over a period of 18 months. The result was that the mother gradually came to understand how she affected the patient; her discussion, although centered only upon the patient's problem, became more objective and concrete. Her mental condition was greatly improved and her scope of interests largely extended, the latter a result of her own initiation. Finally, in view of her own definite improvement, her entire treatment was carried by the worker.

When carried on this basis, there is need for very close planning on the part of psychiatrist and social worker, to avoid confusing the parent as to the part of each. Each interview must be reviewed in detail, the process guided by preceding material covered.

In other children's cases, the social worker may be called upon to work jointly with the psychiatrist in treatment of the hospital patient's problem. An example is when the worker serves as a "good mother" to the child on an individualized basis. She regularly participates with the child at play and in concrete ways attempts to develop his expression of feeling and thinking, carefully observant of his imagery and use of play material. Such a relationship does not supplant the physician's regular interviews, aimed to treat the child by means of play technique. Whereas, in latter instance, the interviews are controlled in terms of time and restricted to the playroom, the social worker's efforts are bent more definitely toward the development in the child of a sense of companionship with greater freedom to enter into active play wherever

he may choose, sometimes including short trips outside the hospital. This relationship with the social worker becomes advisable rarely, but is of benefit in cases where the patient is removed by distance from his family or where the patient's own mother cannot be incorporated to assume this position for the patient, and when individualized outside attention is recommended in addition to that received from the nurses, teachers and others in charge of the group.

Adults:

There are many instances, especially with adult patients partially or wholly emancipated from their families, in which concentration of effort on the part of both psychiatrist and social worker centers upon the treatment and rehabilitation of the patient. In other instances, the social worker's efforts, following social study, may continue both with family and patient, latter in collaboration with psychiatric treatment of the patient. The social worker's need to recognize her aims in view of the patient's psychopathology is of great significance in all such situations.

In general, it could be stated that she should aim to stimulate the interests of a schizophrenic patient, to extend gradually the interests of a recovering manic-depressive type and to stabilize and routinize, as much as possible, the fluctuating, impulsive behavior of a psychopathic personality. She should realize that in dealing with the paranoid personality she is undertaking to externalize, as constructively as possible, a serious projection of ego inferiority and that her efforts should accent the building in of the patient's confidence in self. The vacillations of the anxious or hysterical neurotic patient require close cooperation between psychiatrist and social worker during the entire period of the patient's treatment, providing social work with the patient is concurrently attempted. The worker must know, likewise, that the protective defenses of a compulsion neurosis are based upon a strong and highly conscious guilt component, and that apparently only a long-time, supportive approach can overcome the patient's tedency to argue and to ensnare the worker in a nonconstructive advice-giving relationship.

With the adult patient, who has had great difficulty in his social

relationships, the worker may serve coincident with his psychiatric treatment, almost as a catalytic agent. She may speed the recovery of the patient by helping him to feel free with her largely through methods of supportive therapy. The regular office interviews are not concerned with his subjective problems, which are handled simultaneously by the psychiatrist and any mention of them by the patient is referred back to the psychiatrist. The patient may discuss his complaints freely and is supported in any concrete efforts that he may be making to keep himself in touch with others. He may talk about his feelings toward others and toward his family, and occasionally, an interpretation of their feelings toward him is of help.

In some cases, where the male patient feels uncomfortable and withdrawn with women, the regular interview with the worker serves as a step in his acceptance of women in his environment. At times the retiring unassertive hospital patient may be drawn out by the worker's participation with him in games, such as ping-pong or checkers. If this is done, outside activity entailing expenditure of money, such as attendance at movies or buying of refreshments, is wisely omitted with an adult patient, which may involve his sense of social obligation and obliterate for him the worker's professional relationship.

When the case is early referred to social service for office interviews with the patient with discussion aimed to embrace the patient's social relationships and interests, there is often achieved among many unconversational and inaccessible patients, a more ready accessibility to the psychiatrist's therapy. As an example of such social treatment participation, a 21-year-old male, diagnosed as dementia præcox, hebephrenic type, was extremely uneasy with women. At his first interview with the worker, he was very uncomfortable, shifted in his chair, bit his fingernails, and evaded looking at the worker. The interview was short, consisted only of general conversation and an appointment was made for one week later. These weekly interviews were continued over a period of several months until the patient's parole from the hospital. The patient gradually became more spontaneous, discussing his complaints against the hospital, his family, former girl friends, etc.

Concurrently, the patient was treated by the psychiatrist who was drawing from him and working through his more personal problems. At the time of his parole, he seemed at ease with the worker and was able to associate with women in a group without feeling uncomfortable. Following his parole, as is necessary with many schizophrenic types, the worker continued her regular contact with the patient to stimulate his interests and to extend his contacts.

In some cases it is felt by the psychiatrist that the patient has concenrated sufficiently on analyzing his emotional problems and that he is in need of applying this understanding to concrete social situations. Then, the worker's approach is more direct and the patient is encouraged to discuss actual situations to be faced, and his feelings about them. The need to externalize and widen the interests of the recovering manic-depressive patient is often referred to social service several months before the patient is ready to leave the hospital. The worker's psychiatric understanding must be turned to skillful use in providing for, as well as graduating the patient's renewed initiative in social interests to avoid overstrain. The worker should recognize in handling the problems of both patient and family, that no amount of social stimulation can early substitute for the patient's sense of loss whether intangible or defined and whether directly concerned within or outside the realm of his family relationships. The patient's need to pour forth his feelings to the worker regarding his social life and interests cannot be restrained, yet the worker's aim toward synthesis rather than analysis of the patient's feelings should be maintained.

The same aim of synthesis holds true, although handled, perhaps, on a more suggestive basis with various forms of psychoneuroses. As an example, a 25-year-old female patient, diagnosed as psychoneurosis, hysteria, was referred to social service for help in securing work and placement outside the hospital, after a period of psychiatric treatment. During the latter she had been encouraged to consider the origin of her feelings of inadequacy, her fears of failure, etc. Since she continued to repeat and did not appear to benefit from psychiatric interviews and since her condition was such as to warrant her parole from the hospital, the case was referred to the worker with recommendation that the patient be en-

couraged to find work and be actively supported in facing concrete situations as they arose. Praise for successes, no matter how slight, plus a direct challenge to continue outside the hospital, were utilized. The patient has been on parole seven months and has been self-supporting during the greater part of the time. In this type of case, the social worker assumes the responsibility for seeing the patient and carrying on the treatment and the psychiatrist serves as a guide who will see the patient if the symptoms presented indicate a need for closer psychiatric participation.

There are numerous cases in which the social worker serves the adult patient directly, only as a medium through which placement, recreation, vocational guidance and work are arranged. Here, participation in the treatment of the patient because of the patient's vast improvement, need take place only on the information-giving and manipulative level. In other instances, although the worker's chief aim is specific—to find the niche that the patient can fill in making a community adjustment—her evaluation of the patient's liabilities as well as his assets is of first importance. Her direct work with the patient to gain his acceptance and cooperation in carrying out a mutual plan, also becomes a part of the formulation of such a psychiatric program.

As an example of the latter, a male patient, 40, came to the hospital in a worried, anxious and depressed condition, repeating that no one could help him. His diagnosis was manic-depressive psychosis, depressed type. His social life had consisted of few friends, with history of no women friends, and a maternal aunt, his only living relative within reach, on whom he had felt some dependence. He had graduated from Harvard, 20 years previously, with a *cum laude* record. His life work had been essentially that of private tutor to children in wealthy families. He was especially proficient in mathematics and languages. Outstanding in the patient's personality was his inability to make contacts. He took life extremely seriously, had no faith in himself, and above all dreaded meeting people or being injected into a crowd. He found himself unable to apply for work, yet considered a regular job his only salvation and expressed his preference to commit suicide if forced to become economically dependent.

It was felt that the crux of this patient's rehabilitation depended upon fitting him to a type of work which would not threaten his personality pattern. His contact with the worker was of incidental benefit in giving him a sense of ease, not only in discussing his concrete problems but in making contact with women. He was referred to an employment agency with which his problem was discussed by the worker, and work was obtained for him as proofreader, statistician and translator on individual jobs, requiring a minimum of social contact. Here the worker's skill consisted chiefly in coping with the patient's liabilities as well as his assets in order to provide a protective environment which could offer, nevertheless, the facilities by which he could function.

Conclusions

The social worker in a psychiatric setting can be actively identified with the therapeutic program from the beginning until the close and following the close of the patient's psychiatric treatment.

With the child, adolescent or young adult patient, the worker's efforts are usually of most benefit when concentrated upon the family which has been and may continue for some years to be the vortex of the patient's life. Here she gleans, from a series of repeated contacts, the picture of those attitudes and emotional experiences which have developed with and surrounded the patient. She lends to the psychiatric history a depth of understanding regarding those conditioning factors which have contributed to the patient's illness, thus enriching the total knowledge of environmental causes. From such a study, her individual social treatment of a parent or key person, or of the family as a whole, is attempted when attitudes toward the patient are at fault and when social treatment would seem instrumental in bringing about change. When there is reason to assume that personalities in the family are too rigid or unstable, or that the family members are too old to respond to individual treatment, the social worker can continue useful by means of a cautious, yet more directive approach. Interpretation of the patient's illness and needs, and substitution or extension of interests for patient and family become a palliative objective in such situations.

With the adult patient, either in clinic or hospital, direct social treatment in combination with the psychiatrist's more fundamental therapy, may often play its part in stimulating the patient toward early discussion of reality problems and plans. Coincidentally, the worker becomes helpful to the psychiatrist on such a basis, by providing an indicator of how the patient meets his daily situations and by helping the patient become more articulate in his expression of this. If the patient, by contact with the worker, is advisedly offered concrete facilities by which to extend his life, the patient's progress and personality difficulties may be more accurately gauged as well as treated by the psychiatrist during the course of therapy.

At the close of the patient's hospitalization or clinic treatment, the worker must stand ready to carry the bulk of responsibility during his readaptation to community life. Here, her psychiatric knowledge as well as her social skills are called into combined play. With full realization of the psychiatrist's interpretation and recommendations, she must carefully evaluate the patient's environment and personality to help him find the place that he may fill in terms of school, social life or employment opportunities. Reinterpretation of the patient to family and community resources, is no small part of the process for such an adjustment.

Much has been said regarding social therapy of an individualized type. Perhaps too much space has been devoted here to approach and treatment process, yet without such preface, a delineation of results is of slight value. In dealing singly with those persons who are not psychotic and who do not present a neurosis more severe than is commonly met in daily life, it seems reasonable to show how the worker may borrow from our total knowledge in the psychiatric field. Where heretofore, defenses, resistance, unusual behavior or mind-sets carried for the worker little meaning beyond her recognition of the client's lack of cooperation, she can today with the psychiatrist's help, understand and accomplish more. When contacting the patient himself, a psychiatric understanding points the way in knowing when to moderate and how to modify her treatment in terms of the patient's illness, with full appreciation of her rôle in synthesis.

The worker, with such knowledge, recognizes danger points in her relationship. She knows the far-reaching effects that guilt or self-blame can bring and employs caution if she must resort to suggestion, questions or interpretation where personality patterns are not clear, or when touching upon areas that may inflame guilt yet unexpressed or unaccepted by the recipient.

Psychiatry and psychoanalytic understanding have contributed much in modifying the worker's technique when dealing with all types of personalities. Throughout the years, the goal in psychiatric social work of modifying environment and extending opportunities for patient and family, remains the same, but the worker's method of approach has changed, as her scientific background and her skills have grown, strengthened by sharing the psychiatrist's knowledge.

THE MECHANISM OF CONTINUOUS BATH THERAPY IN EXCITEMENT

BY G. M. DAVIDSON, M. D.,
SENIOR ASSISTANT PHYSICIAN, MANHATTAN STATE HOSPITAL, WARD'S ISLAND, N. Y.

Orientation

"Mental excitement" is admittedly an inadequate term. Still, it is commonly used and conveys the meaning of psychomotor overactivity. In view of differences in expression of overactivity, it may be regarded as a collective term for various hyperkinetic and affective states. The present discussion shall occupy itself with only a few forms of excitement, investigating chiefly the nature of the latter. It does not concern itself with the whole problem of a psychosis in the course of which excitement may be observed.

Depending upon the degree of expression, excitement may be influenced by means of drugs, occupational therapy or psychotherapy. It may, however, become so severe that none of the mentioned forms of treatment will help, and the patient may continue indefinitely in an excited state. In such cases, which are frequently admitted to our hospital, treatment is a difficult problem. The continuous bath offers considerable aid in the care of said cases. In fact, this therapy is accepted as a standard form of treatment with favorable reports of results. This being so, we still know very little about the mechanism at work which is essential in order to evaluate properly the results. Moreover, better knowledge of this form of therapy may, perhaps, throw some light upon the nature of excitement.

Textbooks on hydrotherapy, as well as special articles on the subject, give us valuable information concerning the problem but the information is rather general in character, or refers to a certain detail only. We shall endeavor, therefore, to bring together certain data, including our own observation, which may help one to understand the mechanism at work.

It is obviously very difficult to speak of the mechanism of hydrotherapy in excitement for the reason that very little is known about the origin of excitement; moreover, hydrotherapy is a physical method, while our approach to excitement is psychological. How-

ever, the complexity may be lessened if we shall investigate, only as stated, the nature of excitement and its expression.

In reference to the latter, the following opinions are of interest. Kraepelin, quoted by Jaspers, stated that since movements of an individual must be regarded as expressions of his personality, the motility in psychosis must be interpreted as an expression of a "sick" personality. Wernicke understood under "psychomotorium" in mental cases, motility inclusive of speech by means of which the patient accomplishes a psychological goal. Such psychological explanation according to him does not exclude an organic basis. Kleist and others have produced evidence that one part or another of the extrapyramidal system is responsible for certain catatonic manifestations. Feuchtwanger studying the function of the frontal lobes suggested that the latter have definitely something to do with emotional disturbances which may obviously influence motility. Jaspers classifies certain types of motility and speech as follows: 1. choreiform, ethetotic and impulsive activity. 2. reactions to body sensations (genital manipulations). 3. expression of sensations (stereotypy). 4. expressive movements (grimaces).

Approaching the subject from a biological point of view, excitement may be considered a form of expression of total affectivity which in turn is constructed and oriented upon the central nervous system. For the present we shall distinguish only two forms of excitement. One, even if exaggerated, is harmonious in its expression meaning that feeling, thinking and action are in unison, as observed in the manic state. The other is explosive or reflex in character as seen in catatonia. The former may be identified with "higher," the latter with "lower" levels of psychical activity. Projecting the same upon the brain it is known that affective responses may be identified with cortical or subcortical activity. Already Bechterev has given evidence that certain affective reactions are present in decerebrated animals. Of special interest for us is the work of Head and Holmes. Head advocates that the sensory pathways lead to the thalamus where they end in the ventral nucleus. The latter transmits them to the "essential body" of the thalamus. The cortex supplies sensory discrimination. This approach finds con-

firmation from other investigators. For instance, Le Gross Clark concludes that with the exception of olfactory impulses all sensory impulses which are destined to reach the cortex have first to filtrate through the gray matter of the optic thalamus. Cortical influence may modify through inhibitory faculties thalamic activity but it must have some dependence upon the thalamus because of the enormous blending of various somatic impulses that enter the thalamus.

The stated suggests an anatomical substratum for expression of excitement. The physiological aspects are discussed by Burridge. Based upon his original experimentations with alcohol, he observes that the potential termed excitability has two independent sources in electrolytes and the state of colloidal aggregation. Their interrelation gives the excitation process which in turn evokes the response. He assumes that a certain level of ionic efficiency of the brain is necessary for the process of excitation. A likely mechanism seems to him an increase of blood supply to a certain area of the brain. This depends upon the smaller vessels, not necessarily involving the total blood supply of the brain (see our work on capillary circulation). This approach appears of interest in view of the accompanying circulatory manifestations of excitement as will be seen later.

With the above in mind we shall consider the following forms of excitement: 1. Excitement of an explosive nature which may be transitory and may episodically repeat itself. 2. The harmonious psychomotor overactivity of the manic phase. 3. The impulsive, stereotyped excitement of the catatonic. 4. The excitement which may mimic a manic state but with admixture of involuntary activity (schizo-manias). 5. Involuntary agitation.

Psychoneural Phenomena of Excitement

In further search for definite localization and neurological pathways of excitement we shall turn to accompanying phenomena of excitement.

It is well known that emotional states through their influence upon the vegetative nervous system may produce considerable physiological changes. Outstanding in our cases are thermal and circulatory phenomena. The question arises, therefore, what re-

lationship exists between the quoted states of excitement and the thermal and circulatory changes. Do these mental and physiological manifestations use common pathways? If so, where can we look for them, and which forces are in operation that are responsible for different reactions produced? For instance, in one state of continuous excitement we have increased temperature and circulation, while in another we find the opposite. To gain some insight into the questions we shall turn to the workings of body heat regulation.

The normal man is able to maintain a constancy of body temperature in reference to inner and outer influences of a moderate degree. A failure in such adjustment may naturally lead to considerable consequences. It is reasonably believed, therefore, that a mechanism must exist which governs such thermostasis. From what is known, we deal with a mechanism of construction and adjustment which has its roots in various systems of the total personality, and which have their peripheral and central representations.

The individual heat regulation depends upon the balance of thermogenesis and thermolysis. Thermogenesis arises from combustion in the cells and tissues. (According to Martin, even in rest the organism produces 1.2 large calories per minute). Heat production may be increased or decreased depending upon the intake of food, activity, oxidation, hormonal influence, function of heat control, etc. Thermolysis is accomplished through radiation, convection and evaporation. It depends upon the temperature of the skin, the rate in which water is evaporated, which in turn depends upon the volume and rate of the circulation of the blood of the skin and action of sweet glands and environment.

The rôle of cutaneous circulation is shown by Barbour. He produced evidence that in response to cold there is a transudation of fluid from the skin capillaries forming a body of fluid in the tissue spaces of the skin which act as an insulator. This causes a decrease in volume of the circulating blood with the result that less heat is transmitted to the periphery. When internal heat is high the process works in reverse. The fluid from the skin tissue spaces re-

enters the blood stream, the blood volume is increased and more heat can be brought to the surface for radiation.

Further influence of the circulating blood upon the process is shown by the fact that warming up the large arteries of the neck causes vasodilatation and sweating, while cooling off the arteries produces shivering.

In reference to central representation of thermostatis, Karplus and Kreidl have shown that electrical stimulation of the hypothalamus produces sweating, dilatation of pupils and rise of blood pressure, a sympathetic syndrome, which leads to the conclusion that the hypothalamus harbors the cerebral representation of the sympathetic system.

Cushing and others have shown that a group of nuclei of the tuber cinerium at the infundibulum controls paraysmpathetic activity.

Fulton and Ingraham have shown that complete decerebration was not necessary to produce the "shame-rage" phenomenon of Bard. The reaction could be observed after bilateral sections of fibres passed from the frontal lobe cortex to the hypothalamus, which leads to the conclusion that the sympathetic system is also dependent upon the frontal cortex.

There is also some evidence that the postcentral sensory area participates in heat regulation. Furthermore, Kennard produced certain experimental evidence pointing to the cortical representation of the autonomic system, showing that the premotor and to some extent the motor cortex of monkeys and apes are instrumental in vasomotor and temperature changes.

Bazett, Appers and Erb brought out that the capacity of temperature control in their animals was associated with greater or lesser preservation of tissue surrounding the third ventricle, the infundibular nuclei, the corpora mammillaria, essentially the preservation of the hypothalamus just cephalic to the copora mammillaria.

Davison and Selby in a case of hypothermia found an angioma situated in the floor of the third ventricle with destruction of the nuclei tuberis proper, partial destruction of supraoptic and paraventricular nuclei, hypothalamic nuclei, such as mammillo-infundibular and pallido-infundibular, the substantia grisea centralis and the interculate and interfornicate nuclei.

Considering the above it is logical to think that the thermogenetic-lytice balance may be affected either centrally or peripherally. Centrally by disfunction of various enumerated cerebral levels; peripherally by the temperature of the blood, and nervous impulses going toward the cerebral level. The nervous roots are the following: the afferent, from the skin and viscera, enter the cord by posterior roots and after crossing ascend to the posterior optic thalamus and further to the cortex. The efferent modify heat loss through vasomotor nerves, sweat glands, erectors of hair and muscular and tissue nerves.

In reference to our patients it has been shown by a number of investigators that heat production in the schizophrenic is reduced. Cameron in a recent article on the subject has shown that the internal temperature of the schizophrenic at room temperature is lower than in the nonschizophrenic. This corresponds with our observation. The response of the schizophrenic to heat is much lower than of the nonschizophrenic, particularly pronounced in the hebephrenic. The schizomanic shows approximately the same reaction as a manic patient.

As to circulation, Freeman and others have shown that the schizophrenic has an abnormally slow circulation time. Looney and Freeman also reported that there is a decrease of the volume of circulating blood in the schizophrenic. This corresponds with our work concerning the reticulo-endothel, showing that the blood volume and ability of blood regeneration is greater in the manic-depressive cases than in schizophrenia.

Circulation Time

According to various investigators it takes an average of 22 to 23 seconds for the blood to pass from the forearm through the heart and lungs to the face. A histamine injection manifests itself in flushing of the face, a warm sensation of same and a "metallic" taste in the mouth. In mental cases it is not always possible to obtain the subjective sensations and therefore the experiment is checked by "flushing." In the present investigation we used histamine phosphate 1:10,000, administering 0.01 c.c. of the solution

With the adult patient, either in clinic or hospital, direct social treatment in combination with the psychiatrist's more fundamental therapy, may often play its part in stimulating the patient toward early discussion of reality problems and plans. Coincidentally, the worker becomes helpful to the psychiatrist on such a basis, by providing an indicator of how the patient meets his daily situations and by helping the patient become more articulate in his expression of this. If the patient, by contact with the worker, is advisedly offered concrete facilities by which to extend his life, the patient's progress and personality difficulties may be more accurately gauged as well as treated by the psychiatrist during the course of therapy.

At the close of the patient's hospitalization or clinic treatment, the worker must stand ready to carry the bulk of responsibility during his readaptation to community life. Here, her psychiatric knowledge as well as her social skills are called into combined play. With full realization of the psychiatrist's interpretation and recommendations, she must carefully evaluate the patient's environment and personality to help him find the place that he may fill in terms of school, social life or employment opportunities. Reinterpretation of the patient to family and community resources, is no small part of the process for such an adjustment.

Much has been said regarding social therapy of an individualized type. Perhaps too much space has been devoted here to approach and treatment process, yet without such preface, a delineation of results is of slight value. In dealing singly with those persons who are not psychotic and who do not present a neurosis more severe than is commonly met in daily life, it seems reasonable to show how the worker may borrow from our total knowledge in the psychiatric field. Where heretofore, defenses, resistance, unusual behavior or mind-sets carried for the worker little meaning beyond her recognition of the client's lack of cooperation, she can today with the psychiatrist's help, understand and accomplish more. When contacting the patient himself, a psychiatric understanding points the way in knowing when to moderate and how to modify her treatment in terms of the patient's illness, with full appreciation of her rôle in synthesis.

The worker, with such knowledge, recognizes danger points in her relationship. She knows the far-reaching effects that guilt or self-blame can bring and employs caution if she must resort to suggestion, questions or interpretation where personality patterns are not clear, or when touching upon areas that may inflame guilt yet unexpressed or unaccepted by the recipient.

Psychiatry and psychoanalytic understanding have contributed much in modifying the worker's technique when dealing with all types of personalities. Throughout the years, the goal in psychiatric social work of modifying environment and extending opportunities for patient and family, remains the same, but the worker's method of approach has changed, as her scientific background and her skills have grown, strengthened by sharing the psychiatrist's knowledge.

THE MECHANISM OF CONTINUOUS BATH THERAPY IN EXCITEMENT

BY G. M. DAVIDSON, M. D.,
SENIOR ASSISTANT PHYSICIAN, MANHATTAN STATE HOSPITAL, WARD'S ISLAND, N. Y.

ORIENTATION

"Mental excitement" is admittedly an inadequate term. Still, it is commonly used and conveys the meaning of psychomotor overactivity. In view of differences in expression of overactivity, it may be regarded as a collective term for various hyperkinetic and affective states. The present discussion shall occupy itself with only a few forms of excitement, investigating chiefly the nature of the latter. It does not concern itself with the whole problem of a psychosis in the course of which excitement may be observed.

Depending upon the degree of expression, excitement may be influenced by means of drugs, occupational therapy or psychotherapy. It may, however, become so severe that none of the mentioned forms of treatment will help, and the patient may continue indefinitely in an excited state. In such cases, which are frequently admitted to our hospital, treatment is a difficult problem. The continuous bath offers considerable aid in the care of said cases. In fact, this therapy is accepted as a standard form of treatment with favorable reports of results. This being so, we still know very little about the mechanism at work which is essential in order to evaluate properly the results. Moreover, better knowledge of this form of therapy may, perhaps, throw some light upon the nature of excitement.

Textbooks on hydrotherapy, as well as special articles on the subject, give us valuable information concerning the problem but the information is rather general in character, or refers to a certain detail only. We shall endeavor, therefore, to bring together certain data, including our own observation, which may help one to understand the mechanism at work.

It is obviously very difficult to speak of the mechanism of hydrotherapy in excitement for the reason that very little is known about the origin of excitement; moreover, hydrotherapy is a physical method, while our approach to excitement is psychological. How-

ever, the complexity may be lessened if we shall investigate, only as stated, the nature of excitement and its expression.

In reference to the latter, the following opinions are of interest. Kraepelin, quoted by Jaspers, stated that since movements of an individual must be regarded as expressions of his personality, the motility in psychosis must be interpreted as an expression of a "sick" personality. Wernicke understood under "psychomotorium" in mental cases, motility inclusive of speech by means of which the patient accomplishes a psychological goal. Such psychological explanation according to him does not exclude an organic basis. Kleist and others have produced evidence that one part or another of the extrapyramidal system is responsible for certain catatonic manifestations. Feuchtwanger studying the function of the frontal lobes suggested that the latter have definitely something to do with emotional disturbances which may obviously influence motility. Jaspers classifies certain types of motility and speech as follows: 1. choreiform, ethetotic and impulsive activity. 2. reactions to body sensations (genital manipulations). 3. expression of sensations (stereotypy). 4. expressive movements (grimaces).

Approaching the subject from a biological point of view, excitement may be considered a form of expression of total affectivity which in turn is constructed and oriented upon the central nervous system. For the present we shall distinguish only two forms of excitement. One, even if exaggerated, is harmonious in its expression meaning that feeling, thinking and action are in unison, as observed in the manic state. The other is explosive or reflex in character as seen in catatonia. The former may be identified with "higher," the latter with "lower" levels of psychical activity. Projecting the same upon the brain it is known that affective responses may be identified with cortical or subcortical activity. Already Bechterev has given evidence that certain affective reactions are present in decerebrated animals. Of special interest for us is the work of Head and Holmes. Head advocates that the sensory pathways lead to the thalamus where they end in the ventral nucleus. The latter transmits them to the "essential body" of the thalamus. The cortex supplies sensory discrimination. This approach finds con-

firmation from other investigators. For instance, Le Gross Clark concludes that with the exception of olfactory impulses all sensory impulses which are destined to reach the cortex have first to filtrate through the gray matter of the optic thalamus. Cortical influence may modify through inhibitory faculties thalamic activity but it must have some dependence upon the thalamus because of the enormous blending of various somatic impulses that enter the thalamus.

The stated suggests an anatomical substratum for expression of excitement. The physiological aspects are discussed by Burridge. Based upon his original experimentations with alcohol, he observes that the potential termed excitability has two independent sources in electrolytes and the state of colloidal aggregation. Their interrelation gives the excitation process which in turn evokes the response. He assumes that a certain level of ionic efficiency of the brain is necessary for the process of excitation. A likely mechanism seems to him an increase of blood supply to a certain area of the brain. This depends upon the smaller vessels, not necessarily involving the total blood supply of the brain (see our work on capillary circulation). This approach appears of interest in view of the accompanying circulatory manifestations of excitement as will be seen later.

With the above in mind we shall consider the following forms of excitement: 1. Excitement of an explosive nature which may be transitory and may episodically repeat itself. 2. The harmonious psychomotor overactivity of the manic phase. 3. The impulsive, stereotyped excitement of the catatonic. 4. The excitement which may mimic a manic state but with admixture of involuntary activity (schizo-manias). 5. Involuntary agitation.

Psychoneural Phenomena of Excitement

In further search for definite localization and neurological pathways of excitement we shall turn to accompanying phenomena of excitement.

It is well known that emotional states through their influence upon the vegetative nervous system may produce considerable physiological changes. Outstanding in our cases are thermal and circulatory phenomena. The question arises, therefore, what re-

lationship exists between the quoted states of excitement and the thermal and circulatory changes. Do these mental and physiological manifestations use common pathways? If so, where can we look for them, and which forces are in operation that are responsible for different reactions produced? For instance, in one state of continuous excitement we have increased temperature and circulation, while in another we find the opposite. To gain some insight into the questions we shall turn to the workings of body heat regulation.

The normal man is able to maintain a constancy of body temperature in reference to inner and outer influences of a moderate degree. A failure in such adjustment may naturally lead to considerable consequences. It is reasonably believed, therefore, that a mechanism must exist which governs such thermostasis. From what is known, we deal with a mechanism of construction and adjustment which has its roots in various systems of the total personality, and which have their peripheral and central representations.

The individual heat regulation depends upon the balance of thermogenesis and thermolysis. Thermogenesis arises from combustion in the cells and tissues. (According to Martin, even in rest the organism produces 1.2 large calories per minute). Heat production may be increased or decreased depending upon the intake of food, activity, oxidation, hormonal influence, function of heat control, etc. Thermolysis is accomplished through radiation, convection and evaporation. It depends upon the temperature of the skin, the rate in which water is evaporated, which in turn depends upon the volume and rate of the circulation of the blood of the skin and action of sweet glands and environment.

The rôle of cutaneous circulation is shown by Barbour. He produced evidence that in response to cold there is a transudation of fluid from the skin capillaries forming a body of fluid in the tissue spaces of the skin which act as an insulator. This causes a decrease in volume of the circulating blood with the result that less heat is transmitted to the periphery. When internal heat is high the process works in reverse. The fluid from the skin tissue spaces re-

enters the blood stream, the blood volume is increased and more heat can be brought to the surface for radiation.

Further influence of the circulating blood upon the process is shown by the fact that warming up the large arteries of the neck causes vasodilatation and sweating, while cooling off the arteries produces shivering.

In reference to central representation of thermostatis, Karplus and Kreidl have shown that electrical stimulation of the hypothalamus produces sweating, dilatation of pupils and rise of blood pressure, a sympathetic syndrome, which leads to the conclusion that the hypothalamus harbors the cerebral representation of the sympathetic system.

Cushing and others have shown that a group of nuclei of the tuber cinerium at the infundibulum controls paraysmpathetic activity.

Fulton and Ingraham have shown that complete decerebration was not necessary to produce the "shame-rage" phenomenon of Bard. The reaction could be observed after bilateral sections of fibres passed from the frontal lobe cortex to the hypothalamus, which leads to the conclusion that the sympathetic system is also dependent upon the frontal cortex.

There is also some evidence that the postcentral sensory area participates in heat regulation. Furthermore, Kennard produced certain experimental evidence pointing to the cortical representation of the autonomic system, showing that the premotor and to some extent the motor cortex of monkeys and apes are instrumental in vasomotor and temperature changes.

Bazett, Appers and Erb brought out that the capacity of temperature control in their animals was associated with greater or lesser preservation of tissue surrounding the third ventricle, the infundibular nuclei, the corpora mammillaria, essentially the preservation of the hypothalamus just cephalic to the copora mammillaria.

Davison and Selby in a case of hypothermia found an angioma situated in the floor of the third ventricle with destruction of the nuclei tuberis proper, partial destruction of supraoptic and paraventricular nuclei, hypothalamic nuclei, such as mammillo-infundibular and pallido-infundibular, the substantia grisea centralis and the interculate and interfornicate nuclei.

Considering the above it is logical to think that the thermogenetic-lytice balance may be affected either centrally or peripherally. Centrally by disfunction of various enumerated cerebral levels; peripherally by the temperature of the blood, and nervous impulses going toward the cerebral level. The nervous roots are the following: the afferent, from the skin and viscera, enter the cord by posterior roots and after crossing ascend to the posterior optic thalamus and further to the cortex. The efferent modify heat loss through vasomotor nerves, sweat glands, erectors of hair and muscular and tissue nerves.

In reference to our patients it has been shown by a number of investigators that heat production in the schizophrenic is reduced. Cameron in a recent article on the subject has shown that the internal temperature of the schizophrenic at room temperature is lower than in the nonschizophrenic. This corresponds with our observation. The response of the schizophrenic to heat is much lower than of the nonschizophrenic, particularly pronounced in the hebephrenic. The schizomanic shows approximately the same reaction as a manic patient.

As to circulation, Freeman and others have shown that the schizophrenic has an abnormally slow circulation time. Looney and Freeman also reported that there is a decrease of the volume of circulating blood in the schizophrenic. This corresponds with our work concerning the reticulo-endothel, showing that the blood volume and ability of blood regeneration is greater in the manic-depressive cases than in schizophrenia.

Circulation Time

According to various investigators it takes an average of 22 to 23 seconds for the blood to pass from the forearm through the heart and lungs to the face. A histamine injection manifests itself in flushing of the face, a warm sensation of same and a "metallic" taste in the mouth. In mental cases it is not always possible to obtain the subjective sensations and therefore the experiment is checked by "flushing." In the present investigation we used histamine phosphate 1:10,000, administering 0.01 c.c. of the solution

per kilogram of body weight of the patient. The drug was injected into the cubital vein (usual intravenous technique).

The patients selected were from 21 to 36 years old and free from any demonstrable physical disease. Twelve cases showed a pronounced manic syndrome and 12 cases were of advanced schizophrenia of the catatonic type. The circulation time was determined under nonbasal conditions prior to the exposition of patients to continuous tub therapy and after eight hours of continuous bath. The average circulation time in each instance was found as follows:

Manic syndrome

before treatment 17.2 seconds after treatment 20.3 seconds

Schizophrenia

before treatment 26 seconds after treatment 24.5 seconds

The above shows the beneficial action of the treatment upon the circulation, the manic case obviously responds quicker than the schizophrenic.

Continuous Bath

A large number of patients receiving prolonged bath treatment were observed over a period of several years. One hundred patients who received about two thousand eight-hour baths were studied. The cases were approximately evenly distributed in the following groups:

Manic excitement
Catatonic excitement
Schizo manic excitement
Agitated depression

The investigation had a practical issue, namely to determine the most favorable conditions under which excitement could be maximally influenced by this form of treatment.

In order to ascertain same we recorded certain data in reference to thermal and circulation phenomena of patients. Thermal data concerned room, body and water temperatures. Circulatory data, in supplement to the above circulatory time, dealt with manifestations of peripheral circulation such as capillary skin reactions, local

edemas, flushing, cyanosis and particularly the time of "cephalic cold" evaporation (evaporation of cold compress to head of patient).

The latter, according to our observation, does not depend so much upon excitement but rather upon the rate of blood flow of the peripheral circulation, the evaporation is therefore quicker in the manic state. Comparative readings of the time of cephalic cold evaporation in relation to the water, body and room temperatures in the individual case served to establish the proper water and room temperature.

Manipulation with the water temperature has also shown to some extent the possibility of influencing favorably the body temperature. The relationship of stated reactions and peculiarities of each form of excitement are seen in the tables I-IV.

Tables V and VI show patients with subnormal temperature, who, in response to elevation of water temperature above the body temperature show a marked and steady rise of the latter.

Conclusions

The foregoing allows one to draw the following conclusions: Considering the psychoneural manifestations of excitements as discussed we may conclude that the pathways connecting the thalamus, hypothalamus, olfactory system, pituitary (?), cortex and spinal cord are used by both thermostasis and expression of excitement, and therefore, may influence each other.

Much more must be learned before we shall be able to speak definitely of the mechanism of hydrotherapy in excitement. We believe however to be in position to confirm the suggestion of Burridge in reference to the rôle of the blood supply to the brain. Our postmortem studies of patients who died of "exhaustion following continuous excitement," have shown, among other findings, changes in vascularity of the brain, particularly changes in capillaries. Moreover different areas of the brain were differently attacked. It was reasonable to conclude that the cellular changes in these cases were secondary to increased capillary permeability. This, of course, does not exclude other constitutional changes which we can not discuss at present. The same studies suggested to us that

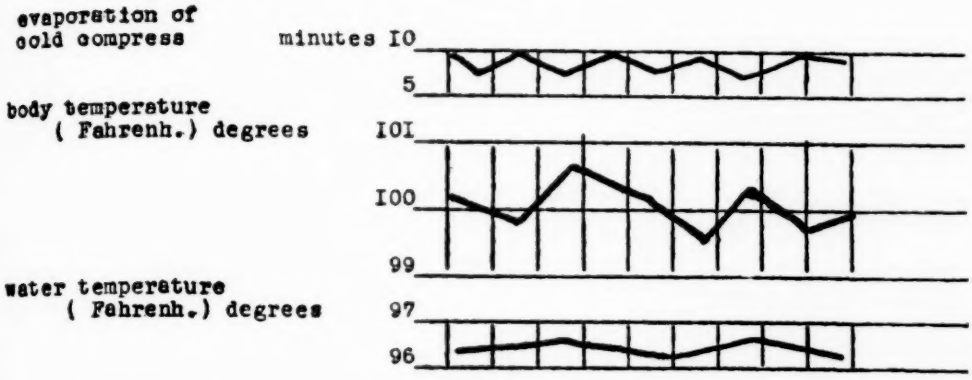
when it comes to considerable fluctuations of temperature in certain cases a definite hypothalamic dysfunction, vascular in origin, ought to be suspected. The same conclusion concerning the rôle of the hypothalamus in reference to heat regulation in schizophrenics is reached by Finkelman and Stephens.

The benefit of continuous bath treatment is believed to be due to improvement in circulation as seen from our experiment with the circlation time and former work on the reticulo-endothel. Another helpful factor is the isolation of the patient during treatment which allows only a minimum of external stimulation, thus giving a rest to the hypersensitized nervous system. The improved peripheral circulation must favorably influence central circulation which shows up partly in improved thermogenetic-lytic balance. It works best in the explosive states of excitement. The severe manic state is very difficult to influence. Application of an ice collar while in the tub may prove helpful. Frequently a manic patient who is continuously restless and incessantly talkative will quiet down after 10-15 minutes of ice collar application.

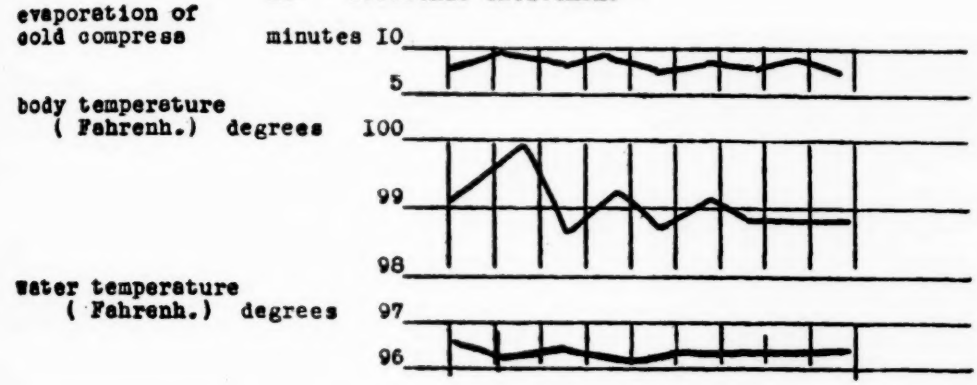
The advisable length of continuous bath time is 16 hours from three successive days up, according to progress shown. The benefit of the eight-hour bath, which we mainly use at the present time, lasts five to six hours, following which time patients become again excited. In order to carry rest until the next morning a sedative must be given. The proper prescription of such a sedative must be based upon the nature of excitement, meaning predominance of manifestation of the cortical or subcortical type of excitement. For example, drugs acting upon the cortex are: potassium bromide, amylene hydrate and paraldehyde; on the subcortical levels: choral hydrate, chloretone, methane, luminal and somnifen. We usually prescribe a combination of both groups such as luminal and paraldehyde or chloral and bromides. In certain cases administration of a sedative is advisable while in the tub. Other medication such as to promote peripheral circulation is also sometimes required.

Diet must be light and nutritious of the "convalescent type"; a glass of milk or eggnog between meals is recommended. It seems helpful for the restless patient.

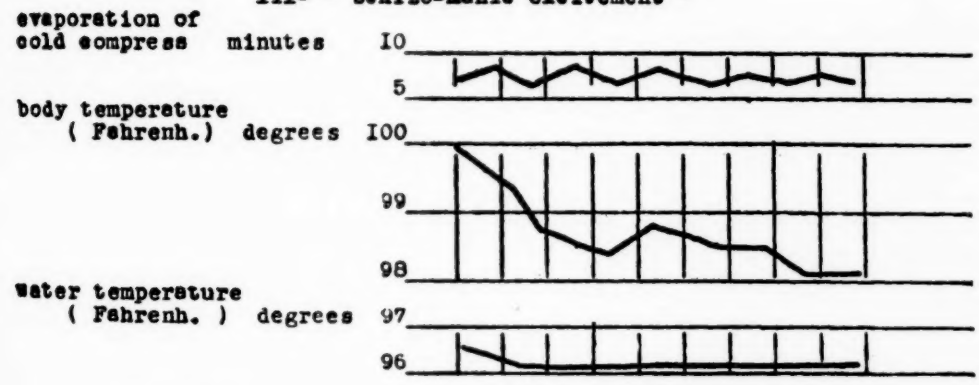
I- " manic excitement "



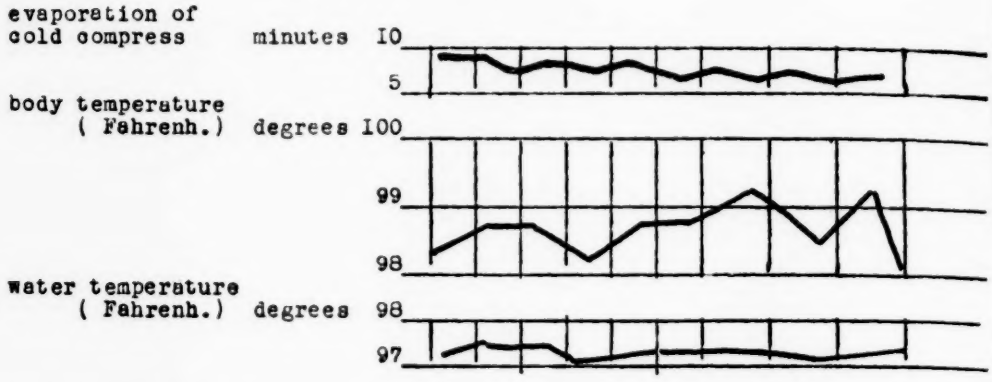
II- " catatonic excitement "



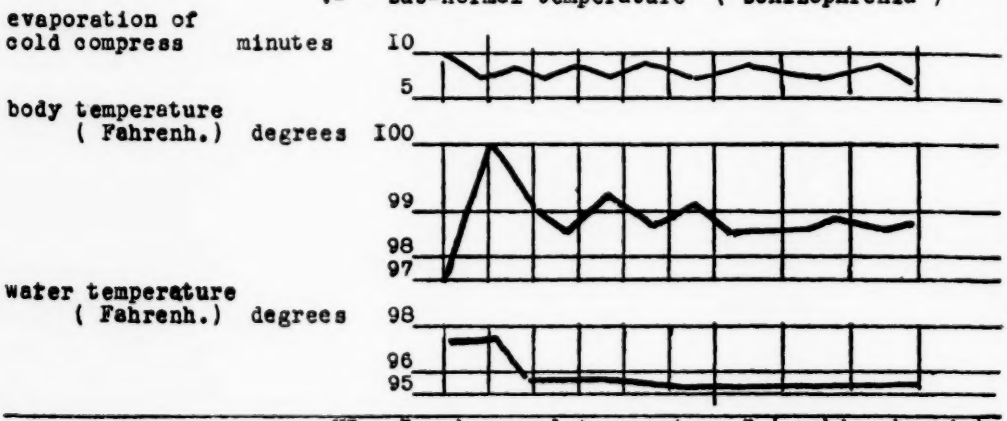
III- " schizo-manic excitement "



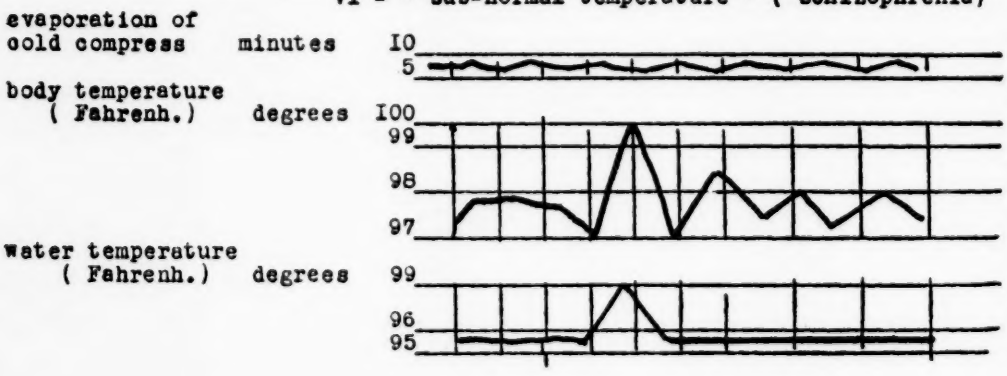
IV- " agitation "



V- " sub-normal temperature "(schizophrenia)



VI - " sub-normal temperature " (schizophrenia)



The room temperature is to be kept at 74 degrees Fahrenheit. With consideration to the individuality of the case, the temperature of the water at said room is usually found best three degrees below the rectal temperature of the patient, in the manic state it may be required even lower. The time of cephalic cold evaporation at the given temperatures is about ten minutes. This seems to be a relative guide for proper water temperature. In cases of subnormal temperature the water is to be raised one degree above the body temperature for one to two hours and later lowered as the case may require after the body temperature rise. (See Tables V and VI).

The psychological element of treatment, as brought out by many workers on the problem, consists essentially in proper preparation of patients to accept this form of treatment.

BIBLIOGRAPHY

Barbour, H G.: Heat regulation and water exchange. Am. J. Physiol., 75:320, 1925.

Burridge, W.: On the excitation process of the conscious and subconscious mind. J. Ment. Sc., July, 1929.

Bazett, H. C., Alpers,. B. J., Erb, W. H.: Hypothalamus and temperature control. Arch. Neurol. Neurol. Psych., Oct., 1933.

Cameron, D. H.: Heat production and heat control in the schizophrenic reaction. Arch. Neurol. Psych., Oct., 1934.

Clark, W. E. Legross: The structure and connections of the thalamus. Brain, 40:406, 1932.

Davidson, G. M.: Concerning the cause of death in certain psychoses. Am. J. Psych., July, 1934.

Davidson, G. M.: Reticulo-endothel: its status in certain psychoses. Am. J. Psych., May, 1935.

Davison, C., and Selby, N. E.: Hypothermia in cases of hypothalamic lesions. Arch. Neurol. Psych., March, 1935.

Feuchtwanger, E.: Die Funktionen des Stirnhirns. J. Springer, Berlin, 1923.

Finkelman, I., and Stephens, V. M.: Heat regulation in dementia præcox. Am. J. Psych., March, 1936.

Freeman, H.: The arm to carotid circulation time in normal and schizophrenic subjects. PSYCH. QUART., April, 1934.

Fulton, J. F., and Ingraham, F. D.: Emotional disturbances following experimental lesions in the base of the brain. Journ. Physiol., 67:27, 1929.

Head, H.: Studies in Neurology London, 1920.

Jasepers, C.: Allgemeine Psychopathologie. J. Springer, Berlin, 1923.

Kennard, M. A.: Vasomotor disturbances resulting from cerebral lesions. Arch. Neurol. Psych., March, 1935

Looney, J. M., and Freeman, H.: Volume of blood in normal subjects and patients with schizophrenia. Arch. Neurol. Psych., Nov., 1935.

Martin, C.: Thermal adjustment of man to external conditions. Lancet, Sept., 1930.

A STATISTICAL STUDY OF BENIGN STUPOR IN FIVE NEW YORK STATE HOSPITALS*

BY HYMAN L. RACHLIN, M. D.,
PSYCHIATRIC DIVISION OF BELLEVUE HOSPITAL, NEW YORK, N. Y.

In October, 1934, the writer presented a followup study of Hoch's original benign stupor cases before the New York Neurological Society.[1] In that paper the writer offered a number of revisions in diagnosis based upon a review of the original material in the light of additional facts obtained by him from the followup investigation. The paper evoked considerable discussion and the point was raised that the evaluation of the findings was subject to the author's personal clinical interpretation of the new data.

The paper which the writer now has the honor to present is the result of an objective statistical followup study upon a large group of cases originally diagnosed benign stupor in various New York civil State hospitals. The subsequent changes in diagnosis in the cases reported in this paper have not been made by the author but by examiners at other hospitals and in various countries. My work has been limited to assembling and compiling these findings statistically.

The task of gathering this material extended over two years, and many of the cases traced were found in Germany, Switzerland, Italy, Porto Rico and British West Indies, and also in various hospitals in this country.

The body of this paper is divided into two parts: (1) a statistical followup of 132 cases so diagnosed by various examiners at the Manhattan State Hospital over a period of 17 years; and (2) a report of the incidence of benign stupor in four other large State hospitals over a corresponding period. The second part also deals with the incidence of benign stupor in relation to the total admissions, and the manic-depressive psychoses in various hospitals.

PART I

At the outset of this study, there were recorded at the Manhattan State Hospital 132 cases of benign stupor over a period of 17 years. Of this group 49 had been discharged, 40 are dead, 24 had

*Read at the ninety-first annual meeting of the American Psychiatric Association, Washington, D. C., May 13-17, 1935.

been transferred to other hospitals, 14 had been deported, and 5 remained at Manhattan State Hospital. Only 17 of the 49 discharged cases could be located despite an exhaustive two-year search; 6 of this group had their diagnoses changed; 3 to schizophrenia, 1 to psychoneurosis, 1 to psychosis with mental deficiency, and 1 to psychoses with other somatic diseases. The diagnoses in 5 of the 40 patients who had died, were revised to schizophrenia prior to their decease. Five of the deported cases were similarly revised, one at the time of deportation and the other four while in foreign hospitals. Of the five cases at Manhattan State Hospital four had the diagnoses revised to schizophrenia. Twenty of the 24 transferred patients likewise were reclassified as schizophrenia. Most of these had their diagnosis altered prior to their transfer, a few however, were reclassified at the respective hospitals to which they were sent. (See Table 1.)

TABLE I. DIAGNOSTIC DISTRIBUTION AND OUTCOME OF 132 BENIGN STUPOR CASES

	Discharged	Dead	Transferred to other hospitals	Deported	Manhattan State Hospital	Total
			Available for followup			
Manic-depressive	11	0	4	0	1	16
Dementia præcox	6	5	20	5	4	40
Other psychoses						
			Not available for followup			
Manic-depressive	32	35	0	9	0	76
Dementia præcox	0	0	0	0	0	0
Total	49	40	24	14	5	132

The above table indicates that 56 cases were available for study and 76 were not available for further followup. I included the five dead patients in the available group because the diagnoses in these cases were revised before their deaths.

Basing our results on the total number of cases we find that over 30 per cent required revision in diagnosis. However, on the basis of the number of cases (56) that were available for statistical followup, we find that 40, or 71.4 per cent, required a revision in diagnosis.

Part II

In order to gain a better understanding of the striking proportion of changes in diagnosis, the writer made a survey of the incidence of benign stupor in four other State hospitals. The hospitals are Brooklyn, Kings Park, Central Islip and Hudson River. The majority of patients in the first three hospitals and those in the Manhattan State Hospital come from the metropolitan area, whereas those in Hudson River come from the smaller neighboring cities, towns, and rural districts.

The survey covered a period of 17 years, thus corresponding with the period during which the 132 cases were distributed at the Manhattan State Hospital.

Although these five hospitals represent only one-third of the total number of civil State hospitals in New York State, the combined admissions to these five institutions, comprise about 67 per cent of the total annual admissions to all the civil State hospitals in New York State.

After all the cases were collected the writer grouped them according to the corresponding fiscal years, and plotted a curve for each hospital representing the number of cases per 1,000 admissions. Since the incidence of benign stupor is partly dependent upon the total admission to each hospital, a corresponding curve for the total admissions was plotted. The total admissions as used by the writer represents the first admissions and readmissions excluding those admitted by transfer. The resulting chart (q. v.) gives a graphic representation of the incidence of benign stupors in the hospitals studied.

Upon examining this graph one is impressed with the steady growth in admissions. While compiling the figures for the chart one noticed that of these hospitals Kings Park and Hudson River showed the least rise, whereas Brooklyn State Hospital showed the most pronounced rise in admissions. The rise of admissions in all these hospitals reflects the general gain.

However, upon examining the curves of the benign stupors for the various hospitals, an entirely different trend was encountered. In all hospitals the number of stupors group themselves around a

Chart II*

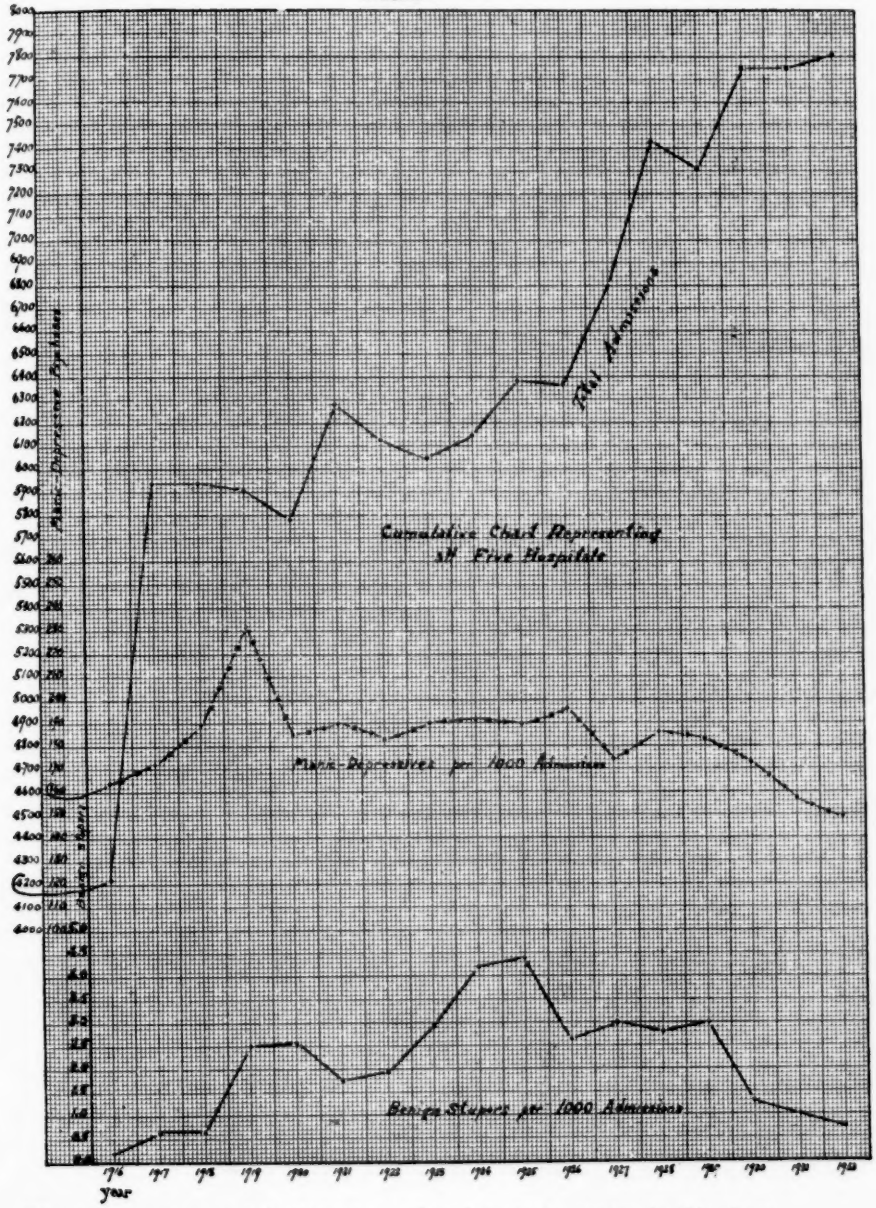


*Chart I is not presented, since its combined features appear in this chart.

certain point, but with a definite tendency to diminish in the past few years. While the tendency to diminish may not have been so apparent from the comparatively few cases in some of the hospitals, the decline was very marked in comparison with the ever-growing rise in total admissions. In other words, while the general admission rate has increased markedly, the incidence of benign stupor has steadily declined.

Since benign stupor is considered a type of manic-depressive psychosis one would expect to find a correlation between the benign stupor subgroup and the manic-depressive group. Such, however, is not the case according to this investigation. It is true that in general there has been a diminution in the number of manic-depressives for the above-named hospitals in the more recent years as compared with previous years; however, the drop in benign stupors is disproportionately greater.* According to the 1931 annual report of the Department of Mental Hygiene the rate of manic-depressives "grew gradually from 4.5 in 1909 to 9.9 in 1922, but there has been no definite trend since the latter year."† This is also true for 1932. The percentage of first admissions of manic-depressives also shows a corresponding rise up to 1923 but with no definite trend after that year.

An examination of Table II will show the lack of correlation that exists between the benign stupors and the manic-depressive group. The table gives, in each case, the number of cases per 1,000 admissions. The striking fact is the divergence one sees from year to year. Frequently when the number of manic-depressives goes up, the benign stupors go down, and vice versa. Often one sees a corresponding drop or rise in each, but the drop or the rise is not proportionate, bearing in mind the previous comparative figures. Similarly one sees striking disproportions as one compares the different hospitals for the same year. It appears that there is no correlation between the benign stupors and the manic-depressive psychoses.

*According to the most recent annual report of the Department of Mental Hygiene one notes that there is an increase in the dementia præcox group.

†The number represents manic-depressive cases per 100,000 hospital population.

TABLE II

Year	Brooklyn		Central Islip		Hudson River		Kings Park		Manhattan	
	B.S.	M.D.	B.S.	M.D.	B.S.	M.D.	B.S.	M.D.	B.S.	M.D.
	Number per 1,000 admissions									
1916	0.00	122.44	0.00	255.99	0.00	58.2	0.00	161.25	0.74	124.62
1917	0.00	89.1	1.17	216.21	0.00	72.3	0.00	162.31	1.01	187.47
1918	0.00	174.5	1.31	222.73	0.00	75.3	0.95	200.38	0.47	188.03
1919	13.00	337.2	2.80	220.58	0.00	102.25	1.02	189.49	0.00	212.60
1920	5.80	205.8	3.90	177.00	0.00	87.37	2.25	246.32	1.07	181.03
1921	1.10	246.0	1.29	213.11	4.90	109.47	0.96	190.89	3.17	171.88
1922	1.90	246.0	1.44	193.78	1.66	126.66	0.99	185.88	3.30	173.11
1923	1.60	237.5	0.69	209.02	4.70	173.98	3.34	147.15	6.42	185.33
1924	1.00	225.5	0.80	166.80	2.74	160.71	3.76	156.16	7.88	220.21
1925	4.10	272.4	0.80	195.18	8.69	144.92	2.79	126.86	8.30	194.43
1926	1.69	229.0	0.00	178.65	2.62	167.97	1.93	146.31	6.10	225.82
1927	1.65	200.9	0.00	147.84	1.41	135.40	4.90	167.64	6.19	191.98
1928	1.44	218.6	1.01	172.57	1.32	166.66	0.00	127.57	7.54	212.60
1929	5.74	208.3	0.00	181.53	2.51	112.09	1.02	114.98	5.86	206.58
1930	0.67	235.8	0.00	163.72	3.63	162.22	0.00	115.35	4.00	178.91
1931	0.65	225.5	1.90	134.22	3.50	156.10	0.00	117.64	1.39	155.98
1932	2.00	221.7	0.50	135.69	3.69	177.12	0.00	85.71	0.87	135.33

B. S.—benign stupors. M. D.—manic-depressives

Another very striking result is found when one compares the individual hospitals as seen from the table below.

TABLE III

Hospital	Total number of first and readmissions from 1916-1932, incl.	Total number of benign stupors from 1916-1932 incl.
Kings Park	16,329	24
Central Islip	24,523	28
Hudson River	11,702	30
Brooklyn	16,497	44
Manhattan	33,483	132

If we compare Manhattan State Hospital with Central Islip State Hospital we see that the former hospital has only about 26 per cent more in total admissions than the latter hospital, nevertheless Manhattan State Hospital had 370 per cent more in benign stupors. On the other hand Central Islip had over 33 per cent above in total admissions over Kings Park yet had only four more cases of benign stupor. A similar disproportion is seen between Kings Park and

Brooklyn where the total admissions are about the same, yet the number of benign stupors in Brooklyn is about twice the number in Kings Park. All this is even more significant when one bears in mind that most patients in the above compared hospitals (with the exception of Hudson River) come from the same metropolitan area.

Let us examine the above findings from another angle. Let us assume that we are dealing with one very large hospital. As I have indicated above, the total number of admissions of these five hospitals represent over 67 per cent of the total admissions of all the civil State hospitals. A comparison of the findings will give us a fair impression of the general trend in the entire system. Again we see that the total number of admissions rises very sharply, that the manic-depressive group shows a gradual decline but not as sharp as the benign stupor curve, and also that a comparison of the number of manic-depressives and benign stupors per 1,000 admissions shows the same divergent tendency as in the individual hospitals. Even here, the benign stupor curve fails to show a correlation to the manic-depressive group or to the total admissions.

To sum up briefly, my findings show that:

a. Of the group that was available for followup, 71.4 per cent required a revision in diagnosis to schizophrenia.

b. The incidence of benign stupor diagnosis definitely diminished in the hospitals studied in recent years.

c. There is no correlation between benign stupor and the total admissions which kept definitely increasing.

d. There is no correlation with the manic-depressive group of which benign stupor is a subgroup.

e. There is a marked disproportion in the number of benign stupors in the hospitals studied.

The above facts lead me to conclude that the diagnosis of benign stupor lacks objective verification. As Henderson and Gillespie indicate, "it is extremely difficult to differentiate clinically the various types of stupor. The stupor of manic-depressive may be in clinical appearance identical with katatonic stupor and the stupor which one sees so frequently in toxic states."[2] This can be

seen from the high percentage of cases that required revision of diagnoses. Further corroboration of this fact is seen from the great diversity in the number of benign stupor cases in the various hospitals regardless of the total admission rate.

The appearance of Hoch's book no doubt acted as a stimulating factor in increasing the number of benign stupor diagnoses, for this diagnosis was made to a much lesser degree previous to the publication of the book, and now is strikingly infrequent.

Considering the fact that 71.4 per cent of the available cases were later rediagnosed schizophrenia would further point to the fact that many of the benign stupors were in reality cases of catatonia.

Furthermore, the uncertainty of benign stupor as a disease entity has previously been suggested by other writers. White states, "this condition of stupor is common in the course of melancholia and occurs as an episode more often than as a distinct form of the disease."[3] Strecker and Ebaugh write, "it is somewhat questionable whether it (benign stupor) occurs often in pure form."[4] MacCurdy, who edited Hoch's book, later said in his own book that "stupor in its simplest form represents only the initial step in regression, the escape from things as they are. Because this is true of all psychopathic reactions it may be said to be the most basic of all regressions, and not specific for manic-depressive insanity."[5] And Henderson and Gillespie, who are well acquainted with American psychiatric thought, state that "Hoch . . . has attempted to differentiate between benign and more malignant forms, but his work, although suggestive, helps very little in the practical differentiation. The cases on which his views are based are not for us very convincing."[6]

The present objective statistical followup study leads the writer to confirm the above opinions and seems to throw further doubt on the value of this concept as a psychiatric clinical entity.

In closing the writer wishes to express his indebtedness to Dr. Willis E. Merriman, superintendent of the Manhattan State Hospital, whose kind help made this paper possible. The writer also wishes to express his thanks to the superintendents of the other

State hospitals for granting him the permission to consult their files, without which this study could not be accomplished.

REFERENCES

1. Rachlin, H. L.: A followup study of Hoch's benign stupor cases. Amer. Jour. Psychiat., 92:531-558, Nov., 1935.
2. Henderson, D. K., and Gillespie, R. D.: A Textbook of Psychiatry. Third edition. Humphrey Milford, Oxford Univ. Press, 1932, p. 154.
3. White, William A.: Outlines of Psychiatry. Thirteen edition, Nerv. and Ment. Dis. Pub. Co., Washington, D. C., 1932, p. 159.
4. Strecker, E. A., and Ebaugh, F. G.: Practical Clinical Psychiatry. Third edition. P. Blakiston and Son, Inc., Philadelphia, 1931, p. 256.
5. MacCurdy, J. T.: The Psychology of Emotion, Morbid and Normal. Harcourt, Brace and Co., Inc., New York, 1925, p. 453.
6. Ibid, p. 154.

A NOTE ON THE RATE OF FIRST ADMISSIONS WITH TRAUMATIC PSYCHOSES IN NEW YORK STATE

BY BENJAMIN MALZBERG, PH.D.
SENIOR STATISTICIAN, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

Patients with traumatic psychoses do not constitute a large group in New York State. On June 30, 1935, for example, they included only 293 of the 59,828 patients resident in the civil State hospitals, or 0.5 per cent. The rate of first admissions is correspondingly low. What is significant, however, is the remarkable upward trend in first admissions with such psychoses in recent years. The rate of increase of these psychoses, as measured by rates of first admissions, exceeds even that of psychoses with cerebral arteriosclerosis.

The following table summarizes the rates of first admissions with traumatic psychoses to all institutions for mental disease in New York State.

The above rates represent smoothed values, the first admissions being averaged for three years. The rate rose slightly between 1911 and 1913, and then declined to 1.7 per 1,000,000 general population in 1919. Since the latter year the rate has increased rapidly and steadily, reaching 9.5 in 1935. The male rate is especially significant. After a downward trend between 1913 and 1919, the rate advanced very rapidly to a maximum of 16.5 in 1935. The female rates were considerably lower than those for the males. They showed little fluctuation between 1910 and 1925. Since the latter year the rate has slowly risen.

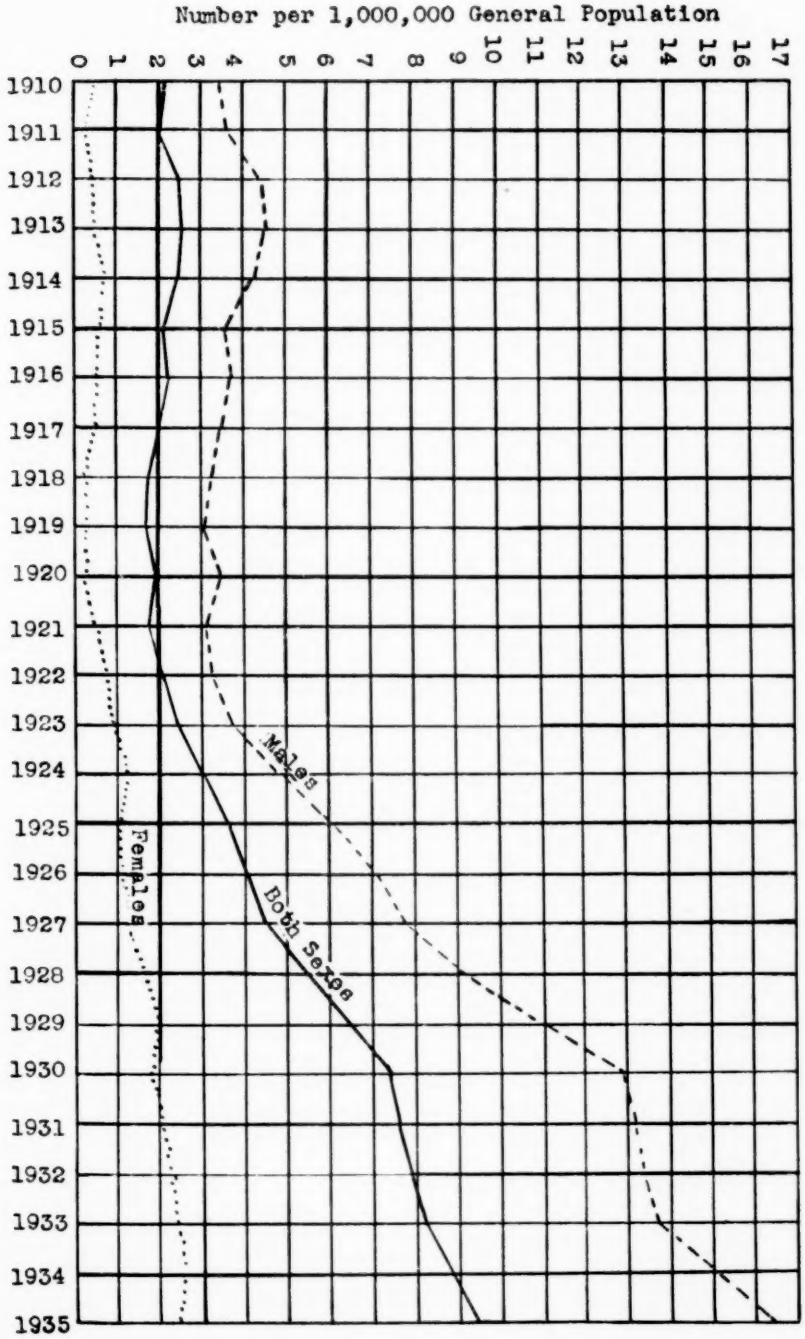
Attention should be drawn to the fact that first admissions with traumatic psychoses have increased in recent years, despite the fact that there have been fewer deaths from accidents in New York State in the same period. Thus deaths from accidents and other violence have decreased from an average of 74.2 per 100,000 population in 1930-1934 to 69.8 in 1935. The death rate from automobile accidents decreased from 23.6 to 22.0.[1] The latter are more nearly comparable with traumas than are total accidents. The same trend is shown if we consider accidents instead of the death rate. In 1930 a total of 97,276 automobile accidents were reported to the New York State Bureau of Motor Vehicles. The following year

TABLE 1. AVERAGE ANNUAL RATES OF FIRST ADMISSIONS WITH TRAUMATIC PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, PER 1,000,000 GENERAL POPULATION, 1910-1935

Year	Males	Females	Total
1935	16.5	2.4	9.5
1934	15.1	2.6	8.9
1933	13.8	2.5	8.2
1932	13.4	2.3	7.9
1931	13.2	2.1	7.6
1930	12.9	1.8	7.4
1929	11.0	1.9	6.4
1928	9.2	1.6	5.4
1927	7.8	1.2	4.5
1926	7.1	1.1	4.1
1925	6.1	1.1	3.6
1924	4.8	1.3	3.0
1923	3.7	1.0	2.4
1922	3.3	0.8	2.1
1921	3.1	0.5	1.8
1920	3.5	0.3	1.9
1919	3.1	0.3	1.7
1918	3.3	0.3	1.8
1917	3.6	0.5	2.0
1916*	3.7	0.6	2.2
1915	3.6	0.6	2.1
1914	4.3	0.7	2.5
1913	4.6	0.5	2.6
1912	4.5	0.4	2.5
1911	3.7	0.2	2.0
1910	3.6	0.5	2.1

*Fiscal year included nine months; rates estimated for year.

there was an increase to 98,552, the highest total recorded in a decade. Since 1931, however, there has been a marked decrease, the total in 1935 being 79,592.[2] The number of persons killed or injured in such accidents has also decreased. The downward trend has occurred, despite an increase in general population and in the number of licensed automobiles. These decreasing trends should imply a corresponding decrease in traumas. Nevertheless, there has been an increase in traumatic psychoses. It is possible, of course, that head traumas may have increased despite a decrease in total traumas, but on this point there are no available data.



First Admissions with Traumatic Psychoses to all Institutions for Mental Disease in New York State per 1,000,000 Population, 1910-1935

Another interesting comparison is that of principal causes of mental disease, other than heredity. I have abstracted the pertinent data from the annual reports of the New York State Department of Mental Hygiene from 1925 to 1935, inclusive.

TABLE 2. PRINCIPAL CAUSES, OTHER THAN HEREDITY, AMONG FIRST ADMISSIONS WITH TRAUMATIC PSYCHOSES TO THE NEW YORK CIVIL STATE HOSPITALS, IN PERCENTAGE, 1925-1935

	Alcohol	Syphilis	Temperamentally abnormal	Senility	Arteriosclerosis
1935	25.2	1.5	54.1	2.2	16.3
1934	29.1	3.4	47.0	0.9	27.4
1933	19.6	0.9	41.1	4.7	19.6
1932	15.6	1.0	44.8	2.0	20.8
1931	21.2	1.0	38.4	1.0	21.2
1930	6.5	..	35.9	3.3	10.9
1929	12.7	1.3	38.0	..	3.8
1928	10.5	5.3	31.6	5.3	5.3
1927	16.0	2.0	34.0	..	..
1926	7.0	..	32.6	..	..
1925	14.6	..	34.1	..	..

The immediate cause of a traumatic psychosis is necessarily a trauma, so that the above table must be interpreted as showing accompanying, or possibly releasing factors. It is interesting to note the increasing frequencies of alcoholism. It is very possible that many of the traumas occurred at a time when the patient was under the influence of alcohol, and as a direct result of loss of motor coordination. Arteriosclerosis also is a fairly frequent factor, though the concomitance may be due to the fact that a relatively large number of patients with traumatic psychoses are at ages favorable to the development of hypertension. The most significant comparison is that with respect to temperamental abnormality. In 1925 almost a third of the first admissions with traumatic psychoses were described as temperamentally abnormal. Gradually the percentage increased until in 1935 more than half were so classified. This bears out the conclusion of Dr. Adolf Meyer, published in 1903, to the effect that there seem to be constitutional peculiarities in persons who develop a traumatic psychosis.[3] In other words

the trauma acts as a releasing factor in an individual who is already heavily tainted with constitutional factors.

REFERENCES

1. See fifty-sixth annual report of New York State Department of Health. Vol. 2, pages xciv-xcix.
2. See annual report of New York State Department of Taxation and Finance. Part III. Bureau of Motor Vehicles, 1935. Page 15.
3. In transactions of American Medico-Psychological Association, Vol. 10, 1903.

SOCIAL COMPETENCE OF THE FEEBLEMINDED UNDER EXTRA-INSTITUTIONAL CARE*

BY EDGAR A. DOLL, PH.D.,
DIRECTOR OF RESEARCH, THE TRAINING SCHOOL AT VINELAND, N. J.
AND
S. GERALDINE LONGWELL, M. A.,
GRADUATE STUDENT, CORNELL UNIVERSITY

It has been evident for many years that permanent institutional care for all the feebleminded is neither practicable nor necessary. Less than ten per cent of the feebleminded, and probably not more than five per cent in most states, become committed to institutions. Of those committed, some run away, some are returned to their homes, some are paroled or discharged, and some are placed out. This "movement of population" in most institutions amounts to a "turnover" of from 10 to 20 per cent annually.

Constructive methods for returning the committed feebleminded to the community have been rather slowly developed, and only by the more progressive institutions. Usually the patient who leaves the institution does so without enthusiasm on the part of the institution, even when the prospect for return to community living is reasonably favorable. Most institutions consider the patient as committed for life, and instead of striving to return the patient to the community, usually do all they can to prevent this. Programs of institutional training usually are designed to prepare the patient for life in the institution rather than for return to society.

There have been intermittent and rather half-hearted attempts on the part of a few institutions to restore patients to family or community life after a period of social training and personal adjustment. But in the main the pressure has been brought by the patient, or by his relatives, or by public opinion rather than by the institution. The typical institution is so absorbed in caring for those patients committed to its more or less permanent care that not much attention is paid to releasing the more promising patients in order that others not yet committed may receive any such care.

*Appreciation is expressed to Dr. Charles Vaux, medical superintendent, Newark State School, Newark, N. Y., for making this study possible.

A few institutions have pioneered in the direction of noninstitutional provision for those feebleminded who can be cared for outside institution walls. These institutions have been advisedly conservative in developing programs designed to restore the feebleminded to the community and to family life. This is partly because of the essential incurability of feeblemindedness and the rather limited prospect that any feebleminded person is a good social risk. The institution also is rather naturally apprehensive regarding the criticism that might be directed toward it if a released patient should subsequently not succeed on his own. These fears are to some extent justified by the ill-advised criticism which the institution receives for the small number of patients who do fail, and the lack of recognition accorded the institution for the large numbers who do succeed. Moreover, no state has built up an adequate program to assist the institution in these extra-institutional programs, which must therefore be developed under institutional auspices.

Every superintendent appreciates that certain patients could safely be returned to their families or restored to the community if the public would support such a program, or if adequate services were available for the community supervision of the feebleminded to which patients leaving institutions could be referred. Lacking such facilities, some institutions have developed programs of colony care for those feebleminded who can be cared for outside the confines of the parent institution. These colonies are usually developed as branches of the institution where the custodial policy of the institution can be more constructively exercised, and where a greater degree of freedom can be granted to the patients. Since the days of Knight, Fernald and Alexander Johnson, such colonies have had a slow but certain development. Bernstein has carried the colony idea to greater lengths than any of his contemporaries, but his success has inspired few followers.

More recently, the idea of family care, so effectively developed for mental patients at Gheel, in Belgium, as well as in Scotland and a few scattered places in Europe, has been receiving favorable attention. The early work done in Massachusetts is now being expanded in New York State with much promise as a means of provid-

ing less expensive, and in many respects more desirable, care than can be provided by the standard institutions.

Programs for the community care and supervision of the feebleminded such as have been developed in England, especially under the auspices of the Central Association for Mental Welfare, have received but little attention in this country. The special class care of the feebleminded has had a vigorous development in many public school centers, but has seldom been correlated with other social measures. This movement has recently been confused by the addition of large numbers of mentally subnormal children who are not feebleminded, that is, who are not socially incompetent but only educationally handicapped.

The feebleminded have traditionally been recognized as socially incompetent persons who are unable to manage their affairs with ordinary prudence independently of supervision because of arrested development of intelligence. This social incompetence of the feebleminded has not been very clearly conceived, and until recently there has been no satisfactory means of measuring its various degrees. Moreover, it has seldom been clear what amounts or kinds of supervision might enable the feebleminded to get along in the community. Few normal children or adults manage their affairs with complete prudence, or with complete independence, or with no supervision. Our social life is such that each of us receives assistance and advice from others in making our way in the world. In the case of the feebleminded, this assistance is presumably more fundamental or more pervasive, yet it is conceivable that some of them might live successfully in society if we could know the exact nature and extent of their incompetence, or could estimate the kind and degree of assistance they require to get along fairly well.

Within the last few years, The Training School at Vineland has succeeded in developing a practicable method of measuring social competence which is especially helpful in evaluating the social incompetence of the feebleminded. This scale, patterned after the Binet-Simon scale for intelligence, makes possible a fairly precise measurement of social competence in terms of genetic maturation or progressive levels of personal independence and social responsibility. The method not only provides a numerical measure of so-

cial competence, but also affords some analysis of the nature of that competence and the directions in which its detailed aspects are at variance with the whole. A large amount of experimental work has demonstrated the practicability of this instrument in relation to various types of the socially handicapped, and especially with reference to the feebleminded.

VINELAND SOCIAL MATURITY SCALE*

Name ..... Age ..... M.A. ..... Date .....
Descent ..... Sex ..... Grade ..... I.Q. ..... Born .....
Occupation ..... Yrs. exp. ..... Class ..... Res. .....
Father's occupation ..... Class ..... Schooling .....
Mother's occupation ..... Class ..... Schooling .....
Informant ..... Relationship ..... Recorder .....
Remarks:

Basal score .....
Additional pts. .....
Total score .....
Age equivalent .....
Social quotient .....
Informant's est. .....

Categories†	Items		
		O—I	
C	1.	"Crows"; laughs
S H G	2.	Balances head
S H G	3.	Grasps objects within reach
S	4.	Reaches for familiar persons
S H G	5.	Rolls over
S H G	6.	Reaches for nearby objects
O	7.	Occupies self unattended
S H G	8.	Sits unsupported
S H G	9.	Pulls self upright
C	10.	"Talks"; imitates sounds
S H E	11.	Drinks from cup or glass assisted
L	12.	Moves about on floor
S H G	13.	Grasps with thumb and finger
S	14.	Demands personal attention
S H G	15.	Stands alone
S H E	16.	Does not drool
C	17.	Follows simple instructions

* Copyright. The standard record blank and the condensed Manual of Directions are on sale by the Extension Department of The Training School, Vineland, N. J., at $3.00 per 100 copies for the blank and $.25 per copy for the Manual.

† Key to categorical arrangement of items:

S H G—Self-help general
S H D—Self-help dressing
S H E—Self-help eating
S D—Self-direction
C—Communication
S—Socialization
L—Locomotion
O—Occupation

I—II

L	18.	Walks about room unattended
O	19.	Marks with pencil or crayon
S H E	20.	Masticates food
S H D	21.	Pulls off socks
O	22.	Transfers objects
S H G	23.	Overcomes simple obstacles
O	24.	Fetches or carries familiar objects
S H E	25.	Drinks from cup or glass unassisted
S H G	26.	Gives up baby carriage
S	27.	Plays with other children
S H E	28.	Eats with spoon
L	29.	Goes about house or yard
S H E	30.	Discriminates edible substances
C	31.	Uses names of familiar objects
L	32.	Walks upstairs unassisted
S H E	33.	Unwraps candy
C	34.	Talks in short sentences

II—III

S H G	35.	Asks to go to toilet
O	36.	Initiates own play activities
S H D	37.	Removes coat or dress
S H E	38.	Eats with fork
S H E	39.	Gets drink unassisted
S H D	40.	Dries own hands
S H G	41.	Avoids simple hazards
S H D	42.	Puts on coat or dress unassisted
O	43.	Cuts with scissors
C	44.	Relates experiences

III—IV

L	45.	Walks downstairs one step per tread
S	46.	Plays cooperatively at kindergarten level
S H D	47.	Buttons coat or dress
O	48.	Helps at little household tasks
S	49.	"Performs" for others
S H D	50.	Washes hands unaided

IV—V

S H G	51.	Cares for self at toilet
S H D	52.	Washes face unassisted
L	53.	Goes about neighborhood unattended
S H D	54.	Dresses self except tying
O	55.	Uses pencil or crayon for drawing
S	56.	Plays competitive exercise games

V—VI

O	57.	Uses skates, sled, wagon
C	58.	Prints simple words
S	59.	Plays simple table games
S D	60.	Is trusted with money
L	61.	Goes to school unattended

VI—VII

S H E	62.	Uses table knife for spreading
C	63.	Uses pencil for writing
S H D	64.	Bathes self assisted
S H D	65.	Goes to bed unassisted

VII—VIII

S H G	66.	Tells time to quarter hour
S H E	67.	Uses table knife for cutting
S	68.	Disavows literal Santa Claus
S	69.	Participates in preadolescent play
S H D	70.	Combs or brushes hair

VIII—IX

O	71.	Uses tools or utensils
O	72.	Does routine household tasks
C	73.	Reads on own initiative
S H D	74.	Bathes self unaided

IX—X

S H E	75.	Cares for self at table
S D	76.	Makes minor purchases
L	77.	Goes about home town freely

X—XI

C	78.	Writes occasional short letters
C	79.	Makes telephone calls
O	80.	Does small remunerative work
C	81.	Answers ads; purchases by mail

XI—XII

O	82.	Does simple creative work
S D	83.	Is left to care for self or others
C	84.	Enjoys books, newspapers, magazines

XII—XV

S	85.	Plays difficult games
S H D	86.	Exercises complete care of dress
S D	87.	Buys own clothing accessories
S	88.	Engages in adolescent group activities
O	89.	Performs responsible routine chores

XV—XVIII

C	90.	Communicates by letter
C	91.	Follows current events
L	92.	Goes to nearby places alone
S D	93.	Goes out unsupervised daytime
S D	94.	Has own spending money
S D	95.	Buys all own clothing

XVIII—XX

L	96.	Goes to distant points alone
S D	97.	Looks after own health
O	98.	Has a job or continues schooling
S D	99.	Goes out nights unrestricted
S D	100.	Controls own major expenditures
S D	101.	Assumes personal responsibility

XX—XXV

S D	102.	Uses money providently
S	103.	Assumes responsibilities beyond own needs
S	104.	Contributes to social welfare
S D	105.	Provides for future

XXV+

O	106.	Performs skilled work
O	107.	Engages in beneficial recreation
O	108.	Systematizes own work
S	109.	Inspires confidence
S	110.	Promotes civic progress
O	111.	Supervises occupational pursuits
S D	112.	Purchases for others
O	113.	Directs or manages affairs of others
O	114.	Performs expert or professional work
S	115.	Shares community responsibility
O	116.	Creates own opportunities
S	117.	Advances general welfare

The present study is a report of preliminary results obtained from applying this Vineland Social Maturity Scale to various groups of feebleminded patients receiving extra-institutional care under the auspices of the Newark State School, Newark, N. Y.

The Newark State School is a large congregate institution for the care of the feebleminded. This institution, under the administration of Dr. Charles L. Vaux, has cautiously but successfully developed a systematic program for the noninstitutional care of patients committed to the school. The success of this program merits

close study. The present study is devoted to a consideration of patients (1) paroled from the institution, (2) in colony care, (3) in boarding home (family) care for children, (4) in boarding home (family) care for adults, and (5) in preparation at the parent school for such placements. The study was made possible by appointment for the summer months of 1936 of S. Geraldine Longwell for the purpose of examining patients assigned to these various units with special reference to their status in terms of social competence. With the assistance of Dorothy E. Jones, social worker at the school, a sampling of patients in each of these groups was examined with the Vineland Social Maturity Scale. A summary of the number and type of patients examined together with the averages and range of deviation in respect to life age (LA), mental age (MA), intelligence quotient (IQ), social age (SA), and social quotient (SQ) is presented in the accompanying table.

TABLE SHOWING MEDIAN SCORES AND EXTREME RANGE OF SCORES FOR VARIOUS GROUPS

Group	No.	LA	MA	SA	IQ*	SQ**	SA-MA Diff.	SQ-IQ Diff.
				Medians				
Resident boys	38	16.4	8.9	11.6	63	71	2.7	8
Resident girls.....	25	16.5	9.3	10.6	67	64	1.3	— 3
Resident women ...	14	30.1	9.2	12.2	65	51	3.1	—14
Farm men	8	27.5	7.8	11.1	56	49	3.3	— 7
Boarding women...	13	49.4	8.2	11.5	59	46	3.3	—13
Boarding children..	13	13.0	7.1	10.5	64	81	3.4	17
Colony women	32	29.3	8.8	13.9	64	62	5.1	— 2
Paroled girls	11	28.3	9.5	15.6	68	66	6.1	— 2
Paroled (self-info.)	..	...	..	16.7	..	71	7.2	3
				Extreme Deviations				
Resident boys	38	12-18	6-12	9-15	48-88	57-89	.6-6.0	—25-27
Resident girls	25	12-20	6-12	8-13	47-91	46-80	—2.1-4.2	—28-21
Resident women ...	14	21-45	7-10	10-14	55-76	43-59	.8-5.4	—28—7
Farm boys	8	19-49	5-11	8-14	41-79	33-70	— .3-6.0	—26-16
Boarding women ..	13	34-60	6-10	8-15	48-76	35-60	— .9-5.8	—37—2
Boarding children..	13	8-18	5-10	6-16	54-77	67-91	.8-6.1	7-34
Colony women	32	17-48	6-12	11-18	45-88	44-96	1.6-8.0	—18-34
Paroled girls	11	17-42	7-11	13-17	55-82	52-95	2.7-8.2	—22-34
Paroled (self-info.).	..	....	....	15-18	....	63-89	4.4-9.0	—13-28

*Stanford-Binet calculated on 14-year adult basis.

**Vineland Social Maturity calculated on 25-year adult basis.

As will be seen from the table, 77 resident patients were examined, including 38 adolescent boys, 25 adolescent girls, and 14 adult women. These patients represent the group from whom patients are most likely to be selected for assignment to the other units. These patients were examined through the ward attendants as informants. (The standard method of employing the scale provides for an indirect examination of the patient by means of an informant presumably well acquainted with him. The scale also provides for a direct examination of the patient acting as his own informant.)

Forty patients in colonies were examined; 8 of these were adult boys in a farm colony, and the remainder were adult girls in domestic service colonies. These patients were examined through their matrons or supervisors as informants.

Eleven girls were on parole in family domestic service, that is, not working out by the day from colony centers. These girls were examined both through their employers as informants and directly as their own informants. Thirteen adult girls in boarding home family care were examined using their family matrons as informants. Thirteen children in boarding home family care, 10 girls and 3 boys, were examined using their matrons as informants.

Before proceeding to detailed comment on the results of these examinations, it may be noted that the use of attendants as informants was not entirely satisfactory because the attendants responsible for large ward groups are not always intimately acquainted with the detailed abilities of their patients in respect to all items of the scale. This limitation was less evident in the extra-institutional groups where the smaller number of patients enabled the informant to be more intimately acquainted with their individual characteristics. However, this limitation is overcome in large measure by limiting the study to patients with whom the attendants were well acquainted. Moreover, the method of examination makes it possible to estimate the extent to which the informant is adequately informed and to discard those examinations where sufficient factual information cannot be obtained.

Another difficulty is present in respect to those items where the environment provides no opportunity for expression of the performance. Thus, the more or less necessary rules, or customary

practices, of institutional administration prohibit the patient from certain performances even if he is capable of these performances. The method of examination provides a special treatment for these "no opportunity" items. In actual practice, however, it is evident that institutional restrictions are relaxed or ignored under certain circumstances, if the patient is definitely capable of the performance without apparent hazard. Enough instances of this relaxation from restriction were obtained to indicate that where the individual can responsibly perform the item in question the restriction is not rigorously imposed. At least this is true in particular instances and for particular items. Here again the method of examination enables the examiner to make a fairly good appraisal of the existing situation.

In the case of the paroled girls, where the examinations were conducted both through the employer and through the patient as her own informant, it is noted that the social scores average about one year higher for the self-informing examinations as compared with those of the standard informants. This is in conformity with results obtained in other studies which indicate that the patient can be used as his own informant with a high degree of reliability as low as an MA of about 6 years. These self-informing examinations typically yield scores about one year higher than those obtained from independent informants.

The reader will make his own analysis of the results in the table. To assist this analysis, the following comments may be made:

1. In the resident patient group, the median SA of the boys is 2.7 years above their median MA; in the case of the girls this superiority is 1.3 years. Since the scale itself does not reflect sex differences, this result is probably due to some difference in the selection of these patients. (With more demand for the release of female patients, the male patients may reflect a larger residue of the socially more capable, even though the residue of girls is mentally more capable than the boys.)

2. The resident women have the highest median SA and the highest excess of SA over MA among the resident patients. This is due in part to their more advanced LA, in part to their slightly higher MA, and in part to selection (the older women being rela-

tively competent patients employed at routine work in the institution). On the other hand, these adult girls have a lower median SQ than the adolescent boys and girls, although the IQ's are about the same. This is most readily explained by the fact that SA's develop to higher LA limits than do MA's (about 25 years and 14 years respectively), but the *rate* of SA growth slows down among feebleminded subjects after about 15 years and reaches a limit after about 18 years, with consequent reduction in SQ after about 15 years.*

3. In the colony patients, it is interesting to observe that both the MA and the SA of the farm boys is lower than for the women patients in domestic colonies. In the farm colony group the median SA is 3 years higher than the median MA, whereas in the domestic service colony women this difference is 5 years.

4. The boarding home women have a median SA which is about the same as those of the other groups excepting the colony women and the paroled girls; the same is true for the difference between SA and MA. However, it should be noted that these examinations represent the higher-grade boarding home women. The low-grade adult women in family care were not included in this study for lack of time to make the examinations.

5. The median SA of the boarding-home children is the lowest of all groups, but these patients also have the lowest median MA and the lowest median LA. When allowance is made for these differences, the boarding-home children are found to have the highest median SQ and the highest median SQ-IQ differences. It is probable that the SQ's in this group will decrease for the group as a whole as age increases, although the SA's may be expected to rise. A few of the patients in this group, however, may be doubtfully feebleminded in view of their relatively high IQ's and relatively high SQ's.

6. The median SA of the paroled girls is the highest of all groups and this is true also of the median SA-MA differences. This is to be expected since these girls exercise the largest degree of freedom, initiative, and responsibility of all the patients studied.

*The SQ method of expressing relative SA corresponds methodologically to the IQ method of expressing relative MA. However, this method of expressing SA data is not wholly satisfactory and should be considered as a tentative method. Therefore, the SQ data are not stressed in this report because of some ambiguity of interpretation due to lack of complete evidence for such interpretation.

7. At the bottom of the table are given the extreme ranges of deviation for the various items. It will be noticed that the highest individual SA's, as well as the highest medians, are found among the colony women and the paroled girls. According to other evidence, SA 18 years marks the approximate upper SA limit for feebleminded patients, and SA 20 years marks the approximate lower SA limit for mentally normal persons. None of these patients has SA higher than 18 years, and only a few reach this limit. The situation is somewhat different for SQ's. Here the tentative norms are SQ 70 for feeblemindedness, SQ 80 for dull-normality, and SQ 70-80 for borderline or doubtful classification. It will be noticed that the upper limit of SQ among these patients is as high as 96. However, the number of such relatively high SQ's is limited (data not presented), and these are found among the younger patients whose SQ's may be expected to drop appreciably between 15 and 25 years (25 years being used for calculating adult quotients).

Discussion

Other studies have shown that the average SA of institutional feebleminded subjects is approximately equal to the average MA up to approximately 15 years, after which the average SA is about one year higher.

In this study the median SA-MA difference in general exceeds these limits and does so conspicuously among the colony women and the paroled girls. In general, therefore, the patients included in this study are relatively more competent on the average than the general run of institutional patients, and this superiority is correlated with the degree of freedom from supervision. There is good reason to believe that this is due to the selection of these patients for extra-institutional care rather than to the consequences of such selection. We may therefore conclude that whatever may have been the method of selecting these patients for extra-institutional care, the system of selection favored patients whose social competence is relatively superior to their mental competence. This is particularly evident from an examination of the range of deviations in the lower half of the table, which shows a definite trend toward plus deviations in favor of SA-MA differences.

On the other hand, this selection in favor of social competence does not reveal differences so great as to indicate that these patients are not feebleminded. On the contrary, none of these patients reaches the SA norm for normality, although some of the younger patients do reach the lower SQ limits for normality.

We may conclude, therefore, that the Vineland Social Maturity Scale is a practical method to assist in the selection of patients for extra-institutional care in accordance with the successful standards now employed.

It should be noted that the selection of patients by institutional standards favors those patients who are well adjusted as to conduct. A distinction may be made between competence and conduct. The patient selected for extra-institutional care should be relatively well adjusted as well as relatively competent for his mental age. The Vineland Social Maturity Scale is not a measure of conduct except insofar as superiority of social competence over mental competence may be taken as a measure of adjustment. It is much better, however, to evaluate adjustment and conduct from other considerations.

Relation of Competence to Environment

Questions may be raised regarding the influence of environment upon social competence and the effect of environmental opportunity or restraint upon the measurement of social competence.

This question may be answered by means of an item analysis of the detailed performances in the social scale. Such an analysis has been made, but the treatment is too intricate for presentation here. (This study involves an analysis of the item performance in terms of the relative difficulty of these items for the different groups.) Without presenting the data we may say with some confidence that this item analysis does not throw any important light on the results above presented.

Especially important in this item analysis is a consideration of those items which are scored "plus no opportunity," that is, performances which presumably would be successful if existing environmental limitations or restraints were removed. Here again

the item analysis is not especially illuminating. This analysis particularly does not suggest that the social competence of these extra-institutional patients is produced *by* the new environment, although it does suggest that such competence is increased to some extent *in* the extra-institutional environment. In other words, the extra-institutional environment is rather more likely to capitalize the underlying capacity for social expression than does the institutional environment.

Summary

This study calls attention to the impracticability of placing all the feebleminded under institutional care and to the desirability of developing extra-institutional programs to provide social supervision and conditions of living in the community which will render the feebleminded most effective at the least cost and the least hazard.

The measurement of social competence of the feebleminded under certain types of extra-institutional care shows that patients now successfully treated in this way have social ages significantly above the mental ages and appreciably more so than for the feebleminded in general. Presumably the empirical methods used in the selection of these patients reflect the importance of this fact. There is a presumption that the use of such a standard measuring device as the Vineland Social Maturity Scale will increase the efficacy of these selections. There is good reason to assume that extra-institutional placement capitalizes competence to better advantage than does institutional care in some directions, and possibly less in others, but the extent of these differences is not clear from this preliminary investigation.

BIBLIOGRAPHY

Anonymous: Colony Number, Training School Bulletin, 12:33-52, April, 1915.

Bernstein, Charles: Colony and Extra-Institutional Care for the Feebleminded. Mental Hygiene, 4:1-28, Jan., 1920.

Doll, Edgar A.: Community Control of Mental Deficiency in the United States. Journal of Mental Science, 79:578-89, Oct., 1933.

——: The Measurement of Social Competence. Proceedings of the American Association on Mental Deficiency, 1935. Pp. 103-126.

——: Preliminary Standardization of the Vineland Social Maturity Scale. The American Journal of Orthopsychiatry, 6:283-93, April, 1936.

——: Social Adjustment of the Mentally Subnormal. The Journal of Educational Research, 28:36-43, Sept., 1934.

——: The Vineland Social Maturity Scale: Revised Condensed Manual of Directions. Publication of The Training School at Vineland, N. J., Dept. of Research. Series 1936, No. 3, April, 1936.

Ecob, Katherine G.: New York State's Accomplishments and Immediate Aims in Extra Institutional Care of Mental Defectives. Proceedings of the American Association for the Study of the Feebleminded, 29:20-31, 1925.

Fernald, Walter E.: The Massachusetts Farm Colony for the Feebleminded. Proceedings of the Conference of Charities and Correction, 1902. Pp. 487-90.

Fox, Evelyn: Community Schemes for the Social Control of Mental Defectives. Mental Welfare, 11:61-74, July, 1930.

Hoakley, Z. Pauline: Extra-Institutional Care for the Feebleminded. Proceedings of the American Association for the Study of the Feebleminded, 27-28:117-37, 1922-23.

Johnson, Alexander: Adventures in Social Welfare. Fort Wayne Printing Company, Fort Wayne, Indiana. Chapter 5, pp. 210-21, 1923.

Knight, George H.: The Colony Plan for All Grades of Feebleminded. Proceedings of Conference of Charities and Correction, 1892. Pp. 156-60.

Mastin, Joseph T.: The New Colony Plan for the Feebleminded. Proceedings of Conference of Charities and Correction, 1916. Pp. 239-50.

Pollock, Horatio, (Editor): Family Care of Mental Patients. State Hospitals Press, Utica, N. Y., Chapter 7, pp. 115-35.

Vaux, Charles L.: Family Care of Mental Defectives. Proceedings of the American Association on Mental Deficiency, 1935. Pp. 168-89.

STUDIES IN OBSESSIVE RUMINATIVE TENSION STATES

IV. *Psychasthenia, Definition and Delimitation*

BY LAWRENCE F. WOOLLEY, M. D.,
TOWSON, MARYLAND

This paper is one of a series of studies in the obsessive ruminative tension states. At this time it has become logical to define more clearly the psychasthenic syndrome in order to prepare the way for the presentation of a study of the dynamic and genetic evolution of such illnesses.

Since this presentation is restricted to an attempt to describe in objective terms those reaction sets which are properly to be designated "psychasthenic," all material extraneous to this purpose has been excluded. We, therefore, deal only with what might be termed "essential" reactions, in contradistinction to the discussion of all symptoms encountered from time to time in such patients. The detailed symptomatology is already adequately described by Janet[1]. The problems of etiology, genesis, and dynamices are also excluded insofar as it is possible to do so.

Although this descriptive approach may seem anachronistic to some and superfluous to others, we must keep in mind that for the present, and probably for a long time to come, the majority of patients suffering from mental illness will be classified in terms of presenting symptoms and signs. The working out of the dynamics and mechanisms in any individual patient may be so prolonged, tedious, and laborious a task, and there is such a divergence of opinion regarding the nature of the processes involved in the various reaction types, that more practical means of differentiation should be sought. What is needed for our diagnostic categories is agreement as to what sorts of reactions belong within them. It makes relatively little difference what words or symbols are selected to represent these categories so long as we are able to understand each other when we use the terms selected. Of course it is important also to avoid distorting the classification by grouping reactions together which are essentially different or by separating those which are alike.

In the set of reactions we are now discussing, the psychasthenic syndromes, it happens that descriptive definition is particularly easy. Those sets of reactions which fall in the middle of the group are distinctive enough to enable most authorities to agree as to the propriety of including them. It is at the boundaries that difficulties may occur.

Dissatisfaction with the implications of the term "psychasthenia" and Janet's[1] interpretation of the dynamics of the illness in terms of "psychic tension" has led many students of this subject to lose sight of the fact that those reaction sets which Janet included under this term properly belong together. These factors have combined to bring about attempts to partition the group into the original components from which it was derived. This has done violence to our grouping rather in the direction of separating types that properly belong together. The result is, that although we continue to use the term in our official classification, there is considerable divergence of opinion as to what may be included under it. Whatever we may think of Janet's interpretation, we must remember the fact that he studied at least three hundred and twenty-five patients in considerable detail and has, therefore, an excellent foundation for his views.

The material dealt with in our own study is composed of gleanings from the literature and a group of 117 patients with whom the author has had personal contact. Many of these patients have been treated by the author; all have been treated under his direction. Among these are several who have been studied and treated by properly trained and qualified psychoanalysts using, in some cases, the orthodox technique, in others, a modification of it. Several others have been used for control analysis by students trained in that procedure under guidance by analysts of recognized merit. The patients are derived from a group of 87 previously reported from the Colorado Psychopathic Hospital, 62 of whom came under personal supervision; 51 patients examined and treated at the Sheppard and Enoch Pratt Hospital during the past four years; and 4 taken from the author's private records. In addition, several children suffering from similar conditions were studied and

treated at the Cleveland Child Guidance Clinic, but this material, not being immediately available for use, has not been included here.

Review of the Literature

I quote from a manuscript translation of Janet's work on obsessions and psychasthenia:[1]

> "The illnesses which form the object of this new study are obsessions, impulses, mental manias, the insanity of doubt, nerve twitchings, agitations, phobias, contact delirium, anxieties, neurasthenias, fantastic feelings of strangeness, and depersonalization often described under the name of cerebro cardiac neuropathy or 'Krishaber's disease.' We find that these patients have been designated under a great variety of names: They are sometimes brought together under the term 'delirious degenerates,' or 'neurasthenics,' or 'phrenasthenics.' * * *
>
> "This bringing together of varying symptoms permits one also to attempt a reunion of different illnesses into one, and to construct a great psychoneurosis on the model of epilepsy and hysteria—psychasthenia—in place of those innumerable obsessions, manias, twitchings, phobias, etc."

He described the important symptomatology under two headings: the obsessive and impelling ideas, and the forced agitations. The latter he describes as mental, motor, and emotional with either circumscribed or diffuse manifestations. Thus under the mental we have manias and ruminations, under motor there occur ties and crises of activity, and under emotional we find phobias and crises of anxiety. He holds that the crisis of anxiety is very frequently diffuse and not attached to any specific ideational content and quotes Pitres and Régis[2] to the effect that diffuse anxiety is an essential element of the obsessions and phobias. In addition the patients manifest, as may be expected, the physiological aspects of anxiety and fear. They are also subject to peculiar and strange emotional states. He points out, as have many other authorities, that the subject is thrown into anxiety by refusal to permit the discharge of obsessions, rituals, etc., which any one can observe who cares to make the experiment on any patient suffering from these conditions.

Important aspects are that these symptoms persist over a considerable period of time or may be regularly evoked by certain stimuli characteristic for the individual patient and that the patients understand that there is something irrational in their behavior.

Practically any of the cases given in any detail in the literature would suffice to illustrate the type. For the sake of convenience the following is given from our own records.

CASE 1. L. W., No. 8176—A woman of 37 was admitted to the Sheppard and Enoch Pratt Hospital on February 12, 1935. Her own complaint was fear of disease and dirt to the extent that it interfered with her whole mode of living. Her husband added that she was constantly scrubbing and washing things. Until the age of nine years she suffered from timidity and anxiety, was afraid of the dark and of being upstairs alone. There were also fears of mice and of bulls and fixed habits, such as wanting to have the curtains drawn when she was in the house. She is described as having been "moody, reserved, keeping her troubles to herself, sensitive, with a terrific fear of doing things wrong, and a fear of responsibility." Throughout school she studied very hard and was never satisfied with her work, going over it again and again. Examinations were difficult because of time limitations. She graduated from high school at the age of 18, but at 14 she had begun to help out in her father's store. She was perfectionistic, given to rigid system and routine, guarded against any possible mistakes, but, in spite of this, lacked confidence in what she did, fearing it would not be right. By 17 she was going over the accounts innumerable times and would repeatedly examine checks to be sure they were right, and then again to be doubly sure. There also developed the need to return to doors several times in order to be certain they were locked. There was no noticeable increase in symptoms until after her marriage at the age of 24. There were many arguments between herself and husband over her extreme conscientiousness, and the sexual problem was always a field of contention since she feared she would be inadequate to raise a child should one result. After six years of married life her husband built a new house. When they moved in they discovered wood lice and from that time on she showed morbid fear of bugs which later became a fear of anything connected with death, such as infections, scratches, germs, ambulances, the color gray, hearses, flowers, funerals, etc. These were all connected with the idea of her mother dying. Since washing her hands relieved the fear and tension, she developed a hand-washing mania. Later on she cried a good deal and was taken to a physi-

cian who discussed sexual problems with her, resulting in some relief of symptoms. However, at 33 she became worse again, fearing she would tell her sister to kill someone and she would be responsible. A second physician advised pregnancy, which she permitted to occur, and she was actually less upset until after the baby was born. The phobias, obsessions and compulsions continued, however, and since they were disconcerting to members of her family with whom she lived, she again became tearful and distressed. She then saw a brown spot on a man's nose and developed fear of cancer. Her husband insisted that she exhibit none of her symptoms to the child and this led to much anxiety and strain. She became progressively worse, was hospitalized with slight improvement, and relapsed as soon as she went home. Further contacts with ideas about cancer increased her fears and hospitalization again became necessary. She was admitted February 12, 1935, and discharged July 17, 1935, having exhibited throughout her stay progressive improvement.

The symptomatology can be summarized as follows: 1—Life-long continuous anxiety. 2—Shyness and timidity. 3—Difficulty in making decisions. 4—Progressive formation of fears, (dark, being alone, mice, bulls, errors in accounts, etc., bugs, death, cancer, germs, dirt). 5—Progressive formation of defences (avoidance of dark and of being alone, having the curtains drawn, overconscientiousness, routine and system, repetition, handwashing, etc.). 6—Affect primarily of fear with some depression. 7—Understanding of the fact that she was ill and that her behavior was irrational.

It is of interest to note that except for such cases as the above in which it is practically impossible to separate out anything corresponding to a true onset of the condition; the large majority of cases described in the literature (wherever sufficient data are given to form an opinion) show either a period or a life-long state, preceding the advent of the obsessive compulsive phenomena, during which the patient suffers from diffuse anxiety with crises corresponding in all respects to an anxiety neurosis. This is also true of all cases we have studied. The following is a fairly good example.

Case 2. I. S. No. 8060—A Hebrew male of 25, the sixth of eight siblings, with a schizophrenic father and a sensitive mother (who has for years been physically incapacitated by encephalitis and diabetes mellitus) was referred to the hospital, October 12, 1934, with the complaint of fears, crying spells, irritability, and withdrawal from contacts. He had been a frail child, with umbilical hernia, emotionally overdependent on his mother, but very

bright intellectually. He made few contacts, was shy, anxious, afraid of the dark, afraid to go places alone, particularly, to get on a street car alone. This was associated with having experienced a thunder storm once while on a street car, since which time he had feared thunder and lightning also. He had a satisfactory but unspectacular work record until about two years before his admission when his present illness began with gradually increasing severity of the personality traits. With the increase of emotional tension came also a lessening of interest and growing irritability, with annoyance at his mother's nagging, and nausea and disgust at her solicitude about him. He became more and more unhappy, felt frustrated and useless, and expressed, at times, the wish to be dead. There were episodes of acute fear reactions in relation to his special phobias. He described these typically as follows: "The further I get from home on the street car, the more my fear increases. I get dizzy and have choking spells and feelings of tightness about my head. My legs get weak and I am afraid something will happen," (that is, he will faint or do something else that will demand attention). He had attempted to overcome some of these fears by facing through the fear situation, but without success. Thus his walking out in the rain to overcome his fear of storms resulted only in greater attention to his symptoms and he was no better. He said, "I know they are foolish and part of my sickness." In the hospital he showed similar reactions to every new or unusual experience—(for example, first trip to the barber shop, to O. T., and to hydrotherapy, etc.). While he showed some disposition to face through such situations, he was also strongly inclined to avoid them. After 12 months of intensive treatment he has lost most of his symptoms, but is not yet completely recovered.

Comment: It is possible that many physicians would classify this as an anxiety neurosis. Some would call it anxiety hysteria. Cases altogether similar to this are described under the heading of anxiety neuroses by Henderson and Gillespie,[3] (they give two cases, both of which show anxiety with crises of fear, phobias and avoidance of situations which serve as stimuli for these reactions), and this is true of most cases of anxiety neurosis presented in the textbooks. The authors referred to above state: "It is probable that the severity and persistence of an anxious preoccupation to an obsessive extent depends on the depth to which the personality is involved and the conflict that produces the symptoms." All three of their cases of psychasthenia began with the anxiety syndrome.

Strecker and Ebaugh[4] present briefly a single case of anxiety neurosis which shows continued anxiety with crises of fear which were not topically assigned to specific ideas (and hence did not rank as phobias) together with indecisiveness, diarrheal attacks and a personality makeup somewhat rigid and subject to previous attacks. These symptoms are reminiscent of the patient presented above prior to the onset of definite phobias precipitated by the thunder storm while on a street car. One of their cases of psychasthenia lacks data on the point under discussion, the other shows the onset of anxiety crises followed by the evolution of obsessions and phobias related to repressed childhood memories.

Gordon[5] presented eight cases, in six of which the patients developed psychoses. In three the data did not cover this point, but in the other five the onset was with anxiety with later development of phobias and defences.

Wulff[6] presents an extremely interesting case in an 18-months-old child who had anxiety attacks occurring regularly between 6 and 7 p. m., with marked increase when a knocking would come at the door. The content was derived from a nursery story. Here there was an anxiety state with crises which crystallized into the fear of being given away.

Bleuler[7] states, "It is the anxiety which in all cases drives the patient to actions or to omit actions. Frequently the patients can somewhat control the obsessions but they are then afraid of the anxiety."

In a like manner the above general ideas hold for the majority of the group of anxiety neuroses and psychasthenic syndromes collected by Southard[8] from the war literature although in many of these war cases the data are inadequate to form a definite conclusion.

In the light of the above, it would seem that the differentiation between many anxiety neuroses and obsessive compulsive psychoneuroses is hardly possible on clinical grounds. Henderson and Gillespie contend that differentiation can be made on the basis of the fact that the patient with anxiety neurosis complains of the anxiety, whereas it is the absurd obsession or compulsion of which the psychasthenic complains. This seems entirely too tenuous a

point for differentiation particuarly because one has only to prevent the discharge of the obsession or compulsion to bring about the most vigorous symptoms of anxiety in these patients and most insistent complaints about it.

If one follows Freud's earlier ideas[9], the problem of this inclusion of anxiety states within the psychasthenic group is avoided for he divided the original group of Janet first into the true neuroses, including neurasthenia and anxiety neurosis (for which he attributed the etiology to disturbances of nerve function at a physical level) and the psychoneuroses, which include anxiety hysteria and the obsessive compulsive syndromes. In some of his later work[10] he seems to be gradually withdrawing from the idea of the anxiety syndrome as a "true neurosis."

More recently still, Fenichel[11] appears to have abandoned the "true neuroses" concept altogether. These writers still tend to differentiate anxiety hysteria from the obsessive compulsive reactions on the basis of the degree of internalization of the anxiety sources. The tendency is to group the anxiety reactions with hysteria as if they were a variety of that condition. Henderson and Gillespie justly take issue with this view on the ground that anxiety hysteria is admittedly not hysteria at all. One advantage of having an opportunity to review a fairly large number of patients as well as a small number of more exhaustively studied cases is that from the large group one learns of certain relationships that could never be discovered by the method of studying a few isolated instances. It is both important and interesting that patients with "anxiety neurosis" and "anxiety hysteria" types of reaction rarely, if ever, develop symptoms characteristic of hysteria proper such as paralyses, anesthesias, fugues, somnambulisms, etc. On the other hand, they quite frequently advance into classical phobic, obsessive, or compulsive states which are admittedly phychasthenic. Fenichel's own cases tend to confirm this view. Jelliffe and White,[12] who in this respect follow Freud's formulations, recognize clearly that these syndromes, particularly anxiety hysteria and the obsessive compulsive group, were embraced in Janet's original concept. They present only fragments of cases taken from Freud.

The case material coming under our observation has not permitted of such differentiations. In the first place the anxiety neurosis group has been traced in the large majority of instances to psychological rather than physical cause, and, in the second place, the psychological causes are intimately related to those underlying the obsessive compulsive syndromes. Moreover, where adequate objective historical material is collectible, the anxiety foundation for the obsessional symptomatology is usually evident. This has greater significance when it is recalled that several cases at the Sheppard and Enoch Pratt Hospital have been studied and treated by qualified and adequately trained psychoanalysts. It is impossible here to elaborate fully on the etiology and psychodynamics of this group of patients as it would occupy more time and space than is available, but we might comment that Greenacre,[13] who made a farily comprehensive study of the dynamic relationships in 82 cases, found the cause to lie primarily in the conflict between desire and fear, and Ziegler,[14] who reported a study of 36 cases, tends to subscribe to this view. Greenacre reported only two cases in any detail, but both of these began with anxiety.

Argument

If in describing the psychasthenic syndrome we adhere rigidly to the observable and recorded facts as we have them, the general statement would be somewhat as follows: The psychasthenic reaction type presents: 1. A basic state of prolonged and diffuse anxiety which develops into crises of anxiety or of fear in response to certain stimuli characteristic for the patient; 2. A more or less well-developed defence, against the stimuli giving rise to the crises, in terms of (a) the compulsion to avoid them, (b) the elaboration of substitutive activities in the form of positive compulsive acts or obsessive thinking; and 3. A recognition of the fact that this behavior constitutes an abnormal state in that, without regard to rationality and capacity, the patient is prevented from satisfying desires that fall within the normal range.

It is true that for many psychiatrists this definition implies an extension of the term to include a large proportion of cases now classified as anxiety neuroses. It should be pointed out, however,

that this is precisely what Janet intended to do in his original formulation and is entirely consistent with the logic of the situation. One could then classify the psychasthenic syndromes under three subheadings depending upon which aspect of the reaction was most in evidence: a. psychasthenic anxiety reaction, b. psychasthenic obsessive ruminative states, and c. psychasthenic compulsive ruminative states. One should note also whether the syndrome is accompanied by motor tics. This would be consistent with what is clinically regularly observable.

The point of greatest departure, between the simpler anxiety states belonging in the psychasthenic syndrome and the other psychasthenic manifestations, is the discrepancy in prognosis. In general the anxiety states which are not overlaid with phobic, compulsive and obsessive phenomena have an almost uniformly good outlook under any intelligent management. The more elaborate the defences become, the more difficult become the problems of treatment and the less likely the patient is to recover. This is precisely what one would expect, of course, since the individual who is able to maintain a fairly calm emotional state by virtue of compulsive and obsessive rites will be most resistant to giving them up; and consequently the treatment of the obsessive and compulsive states has to do first with the resolution of the defences and secondly the solving of those problems which give rise to the basic anxiety. If the first task can be accomplished, the second presents relatively little difficulty.

This discrepancy in prognosis, then, should not lead of itself to a separation of reaction types so logically related and belonging to one another. One does not, for example, exclude from the category of hysteria its milder and most easily treated forms simply because there is a considerable group of hystericals who present such serious obstacles to treatment that recovery is not obtained.

Course: While the psychasthenic syndrome has its roots in the anxiety in its ultimate extremity it frequently passes into the schizophrenic syndrome, as has been previously shown.[15] The line of demarcation here should be in terms of retention or loss of the reality perception. At this point we have a change in direction of the reaction which passes from reality into fantasy with distinct

hallucinations and delusional phenomena. Not infrequently patients who have suffered for a long time with phobic and compulsive symptoms pass into a state of apathetic inertia in which activity is markedly reduced, feelings of unreality are notable, and the chief complaints are of weakness, fatigue, and pressure sensations, but the underlying anxieties, phobias, et cetera, can be elicited in the history and by questioning. These represent the psychoneurotic psychotic borderland.

Personalities presenting the psychasthenic reactions in fairly pure form have been encountered in the following categories.

1. Patients presenting isolated episodes, but maintained over a considerable length of time, which originate in specifically traumatic precipitating situations in personalities that have shown previously no marked tendency to such reaction formation of which the following is an example.

Case 3. A white male of 29 years, from sound stock and previously outgoing and well adjusted, was precipitated into an anxiety neurosis with fear of committing suicide by being subjected to the partial effects of a discharge of lightning. Fifteen months later, during an operation for right inguinal hernia, the left testicle was removed as it was found to be sarcomatous. This experience left him subject to recurring attacks of crises of anxiety and fear with mild feelings of depression but without any tendency to self-blame. The anxiety became more continuous and the crises more severe until he was finally hospitalized at the age of 32. The condition cleared up to a great extent following intensive psychotherapy. During his hospitalization he was found to suffer from continuous tension, crises of anxiety, and phobias and obsessive rumination connected with fears of suicide and loss of his testicle. The case is reported in detail elsewhere.[15]

Ziegler's[14] Cases 5 and 7 appear also to belong to this group.

2. Progressive, continuous development from infancy as in Case 1 above and, as represented in its earliest phases, suggested by Freud's Kleiner Hans,[16] and by the case above quoted from Wulff, and to which category also belongs the life story contained in William Ellery Leonard's "The Locomotive God."[17] The terminal state may be one of severe psychasthenia or even schizophrenia. Ziegler's Cases Nos. 1, 2, 3 and 6 probably belong here.

3. Cases showing the development of psychasthenic mechanisms to some degree of compulsion and phobia formation frequently together with collecting or athletic hobbies and with tendency to scrupulosity and overconscientiousness (which altogether might be considered the psychasthenic personality as distinct from the psychasthenic illness) who are able to maintain throughout life a sufficiently comfortable adjustment to avoid the distinct outbreak of anything that could be considered in the nature of a definite mental illness. These, of course, rarely come under the purview of the psychiatrist as patients. One recalls them as people one knows or has known among colleagues and associates.

4. Psychasthenic personalities (as discussed under the third heading) who show exacerbations from time to time in frank episodes of psychasthenic illness. It is possible that some of these patients represent a depressive reaction superimposed upon the psychasthenic personality.

Case 4. M. B. A woman of 60 years who had always been extremely scrupulous, religious, and given to much praying, overconscientious regarding money and truth, had been ill for two years with symptoms of increased conscientiousness, praying, etc., with obsessions, phobias, and rituals grouped around the ideas of dirt and contamination. There were also obsessions concerning burning others, with defensive rituals against them. Aside from a similar episode at the age of 54, which lasted six months, she had been well adjusted within the limits of her rather rigid personality. Both episodes were precipitated by considerable loss of emotional ties and property.

Case 5. E. C. A wealthy man of 72 years, overconscientious from early childhood, extremely methodical, very dependent on routine and throughout life developing anxiety and tension when not occupied, had no frank outbreak of illness until the age of 60 when he was on vacation. He exhibited anxiety, obsessive thinking, doubting "mania," and indecision, but recovered without treatment on return to his business after a few months. At 70 he became ill with similar symptoms upon retiring from business. Return to work after four days resulted in recovery.

Ziegler's cases Nos. 4, 9, 10 and 11 would be grouped here.

5. Personalities less well-adjusted than those just discussed that show throughout life more or less continuous anxiety with exacerbations from time to time in frank, obsessive and compulsive (or

even at times schizophrenic) episodes. Into this group would probably fall those cases which recover from schizophrenic psychosis by means of organizing an obsessional psychoneurosis.

CASE 6. O. S. A Jew of 48 years suffered from earliest childhood from anxiety for which he gained partial compensation in meticulous performance, avoidance of situations of stress and rituals of touching. At 16, following an unsatisfactory love affair, he again became upset. He at this time lost contact with reality and for a few days was mildly delusional. He was then restored to his former level where he remained until the age of 41. Then following business failures and loss of employment, he became progressively more anxious, and developed phobias with increase of rituals and compulsions to the degree of a severe psychasthenic illness with some reality distortion. After several months treatment he was again at his usual level.

Ziegler's case No. 8 belongs to this group.

6. For the sake of completeness, we should add psychasthenic syndromes occurring without evidence of predisposition to psychasthenic reactions as the equivalents of depressive episodes in the course of manic-depressive histories. The following case is a very clear example of this.

CASE 7. S. S. No. 8322. A white single woman of 65 had suffered from a series of circumscribed depressions, the first at the age of 38, the second at 46, the third at 54. She had been, in early life, outgoing, with innumerable interests, with an excellent school and work record up to the time of her second depression. Aside from anxiety in the first illness there had been no evidence of impurity of affect in the episodes, and aside from some tendency to neatness and progressive dependence on routine, had otherwise exhibited none of the psychasthenic patterns. Each depression was ushered in with a period of what she felt as physical exhaustion. Following a period of anxiety regarding a pending operation for removal of a fibroid uterus, she again became blue and depressed, felt exhausted, and then began to elaborate a series of phobias and obsessions from which she has not yet recovered.

Differentiation

Perhaps the boundaries of the psychasthenic reaction type as it is here conceived will be better recognized by a brief comparison with other syndromes.

1. We have to consider first a group of anxiety states some of which are related to physical disease, such as hyperthyroidism, extensive disease of the mediastinal contents and other gross physical incapacities. We have on occasion observed the onset of general paresis with the advent of anxious tension, phobias, and compulsions. It is probably also desirable to separate from the psychasthenic syndrome proper those anxiety states which arise from immediate and objectively real situations in which the individual experiences prolonged frustraneous excitement or prolonged periods of actual insecurity which do not appear to be related primarily to memory content and are, therefore, not accompanied by much rumination and in which the typical defence mechanisms of definite obsessions, phobias and compulsions are lacking. This conforms more or less to the views of Meyer[18]. It has the advantage of excluding from the group those anxiety states which may pass directly into hysterical, manic-depressive, or schizophrenic episodes, and avoids the connotation of attempting to forecast the future, although most of them will develop the phobic and compulsive trends unless the anxiety is resolved. These may be in the group Fenichel referred to as more externalized, but even here one must recognize an internal component that becomes more and more important. Where the anxieties become organized in any way which compels avoidance, we are already dealing with the psychasthenic syndrome. The "anticipation" anxiety states which are more or less normal preceding critical tests and events in life should be excluded.

2. Although occasionally isolated hysterical phenomena have been exhibited in patients showing otherwise typical psychasthenic reactions, this is by no means a common occurrence and the differentiation from the hysterical syndrome can usually be made on the basis of the facts that functional losses of the order anesthesiae, motor paralyses, etc., are lacking, true automatisms, such as somnambulism and automatic writing, occur but rarely and the patients, excepting in the direction of adding to their symptomatology, are relatively insuggestible. One would also note that in general the psychasthenic patient does not manifest the apparent in-

difference to his incapacities that is so frequently a characteristic of the hysteric.

3. Those psychasthenic syndromes occurring as the equivalent of depressive episodes in the course of recurring attacks of manic-depressive reaction should be grouped rather with the affective psychoses than with the psychoneuroses.

4. We have already mentioned the basis for differentiation between the psychasthenic syndrome and the schizophrenic reaction type, in terms of the preservation or loss of orientation to objective reality.

5. Patients who exhibit psychotic or psychoneurotic reactions in the presence of mental deficiency or psychopathic personality frequently show extensive admixtures of reaction type in which occasional or more continuous use of psychasthenic reactions is not uncommon. Where these reactions occur more or less continuously and with little admixture of other reactions, we would consider them as belonging to the psychasthenic syndrome. Where the admixture is more diversified, the only possibility of classification is to enumerate the range of symptomatology manifested.

Summary and Conclusions

Data from the literature and case material have been presented with a view to clarifying the boundaries which limit the range of the psychasthenic syndrome. From this material it appears that the psychasthenic type of reaction is a special defence against prolonged states of anxious tension. In its larval forms it is manifested as a compulsion to avoid sets of stimuli to which the patient has characteristic sensitivity and in its more elaborate forms interposes between the subject and the noxious situations activities in the form of obsessive thinking and compulsive acting. In both instances the patient is properly oriented to objective reality and understands his behavior as abnormal. It is felt that this discussion might help to resolve some of the confusion which results when one attempts to group a portion of clinically similar phenomena (anxious tensions with phobias and the compulsion to avoid) under the separate headings of anxiety neurosis or anxiety hysteria.

REFERENCES

1. Janet, Pierre Marie: Les Obsessions et La Psychasthenie, 3rd Ed., Alcan, Paris, 1919.
2. Pitres et Régis: Séméiologie des obsessiones et des idées fixes. Rapport au Congrès de Médicine de Moscou, 1897, p. 19.
3. Henderson, D. K., and Gillespie, R. D.: Textbook of Psychiatry for Students and Practitioners. Oxford University Press, New York, 1927.
4. Strecker, E. A., and Ebaugh, F. G.: Practical Clinical Psychiatry. P. F. Blakiston's Sons and Co., 3rd Ed., Philadelphia, 1931, p. 406 et seq.
5. Gordon, A.: Obsessions in their relation to psychoses. Am. J. of Psychiatry, April, 1926, Vol. V, p. 647.
6. Wulff, E.: Int. J. of Psychoanalysis, Vol. IX, Part 3.
7. Bleuler, E.: Textbook of Psychiatry (trans. by Brill). Macmillan Co., New York, 1924, p. 562.
8. Southard: Shellshock and Neuropsychiatry. W. M. Leonard, Boston, 1919.
9. Freud, Sigmund: Collected Papers. International Psychoanalytical Press, New York, 1926. The Anxiety Neuroses, p. 76 et seq. Obsessions and Phobias, p. 128 et seq.
10. Freud, Sigmund: Inhibition, Symptoms and Anxiety. Monograph series No. 8. The Psychoanalytic Institute, Stamford, Conn., 1927.
11. Fenichel, Otto: Outline of Psychoanalysis. W. W. Norton, New York, 1934, p. 46 et seq.
12. Jelliffe and White: Diseases of the Nervous System—4th Ed. Lea and Febiger, Philadelphia and New York, 1926, p. 865 et seq.
13. Greenacre: A study of the mechanism of obsessive compulsive conditions. Am. J. Psychiatry, 1923, Vol. XI, p. 527.
14. Ziegler, L. H.: Compulsions, obsessions, and feelings of unreality. Human Biology, Vol. I, Dec., 1929, p. 514.
15. Woolley, L. F.: Studies in obsessive ruminative tension states—I. Relation to paraergastic reactions. Am. J. of Psychiatry, Vol. IX, May, 1930, p. 1113.
16. Freud, Sigmund: Analysis of a Phobia in a Five-Year-Old Boy Collected Papers, Vol. III.
17. Leonard, William Ellery: The Locomotive God. Century Co., New York, 1927
18. Meyer, Adolf: Manuscript of Lecture Notes to Students.

EXTRAMURAL CARE IN NEW YORK STATE

With Reference to Persons with Mental Disorders and Mental Deficiency

BY REGINALD R. STEEN, M. D.,
MEDICAL INSPECTOR, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

In New York State there are in operation several methods of providing community or extramural care for persons with mental disorder or defect. The best known and most widely used is the direct parole or discharge of a person from an institution to a relative, friend or employer who accepts all responsibility for the patient. This type of care is standard and so well known that it is mentioned only for completeness.

Nursing Homes

The method of caring for the mentally handicapped in nursing homes is one to which Smith[1] has called our attention. Many individuals decide on their own initiative to go to these homes; others are taken there because they are dotards or mild seniles or arteriosclerotics who are unable to care for themselves, and whose families are unable to give them sufficient care. Nursing homes are usually private homes operated by a practical or trained nurse who cares for from two to 10 of these persons for a small consideration —$10 to $25 per week. The patients are, in most instances, treated kindly, kept clean, given enough to eat and are happy and contented. Nursing homes of this type have been in operation in England and Scotland for many years. The following is a brief description of one the author visited in August, 1936, in Edinburgh under the direction of Dr. David Henderson.

It was a medium-sized, two-story brown stone structure which was formerly occupied by a private family. The house was located in one of the middle class residential sections of the city with private homes only a few yards distant on either side. A nurse and attendant lived there with eight patients. One patient was disturbed and in a pack, one moderately depressed, one agitated and the others quiet. Dr. Henderson said the neighbors had made no

complaint. He also said that patients may be admitted directly from their own homes and held against their will on a voluntary application providing their relatives bring them in. The home may not send for them. One would expect complications from this type of commitment but Dr. Henderson stated that, strange as it may seem, there are none. Since the atmosphere of these places is more homelike than that of a hospital or private sanatorium, the patients are usually more contented than they would be in a large institution.

There are many nursing homes of this type in New York State but, since they are not licensed, they are not all known to the Department of Mental Hygiene. The author, while performing his duties as medical inspector, has had an opportunity to observe several of these homes and believes they serve a very real purpose. He feels that, as Smith has pointed out, they should be licensed and all regularly inspected so that suicidal or otherwise unsuitable individuals will not be cared for in them. Eleven such homes known to the department are visited regularly every three months by officers of the bureau of inspection. The discharge of unsuitable persons who are occasionally found in them is recommended, and this recommendation is usually carried out. However, if it is not, experience has shown that very little can be done about it, as court decisions are too frequently unfavorable. If the homes were licensed, as they are in England and Scotland, the license could be rescinded if proper standards are not met, and, if necessary, more definite legal action taken to control individuals who failed to comply with department regulations as to the operation of the enterprise.

Colonies

The third type of extramural placement is known as the colony system of care. This method was started by the superintendents of the Syracuse and Rome State schools, and the colonies of these institutions were well developed by 1927 when these State schools came under the direction of the State Department of Mental Hygiene. There are many minor variations, but in general a colony consists of 12 to 30 suitable patients who are placed in a private home or on a farm which has been rented or purchased by the in-

stitution. The supervisor and matron, a man and his wife, who have had experience in caring for these patients, are in charge of the colony and supervise and train the patients. As a rule, the colonies are located adjacent to, or within a few miles of, the institution. At Syracuse, the boys' colonies, with the exception of one at Camillus, are located in a group on a large elevation of land at Fairmount, N. Y., just outside the city limits of Syracuse. The boys at the six farm colonies are taught the principles and practice of farming, growing crops and caring for farm animals. These colonies are practical and in size and operation are similar to private farms in the neighborhood, so that the boys will be required to make very little adjustment when they are paroled to work for the neighboring farmers. The colony houses are furnished as much like private homes as possible; and the supervisors and matrons are selected for their fatherly and motherly attitudes, in the hope that they will prove good parent surrogates to the boys.

There are also five school colonies located with this group at Fairmount. The patients in these colonies are younger boys who are sufficiently intelligent to profit from academic instruction. Classes are held in specially constructed classrooms in each colony house. A modern amusement hall is here for the patients' enjoyment, and it is not only the social center but also the center for manual training and physical education.

The Rome State School has established some 60 colonies which care for more than 1,100 patients, almost equally divided as to sex.

The majority of the boys' colonies under the supervision of this school are conducted in general like the farm colonies at Fairmount but they are scattered over a large area instead of being grouped together in one small locality. They are situated in the Mohawk Valley between Hamilton and Oneida, except one which is located east of Albany, near Niverville, N. Y. Two similar colonies for boys are operated from the Newark State School. Both are near the institution.

A different type of colony known as a boys' industrial colony is operated by the Rome school. It is located in the city of Rome. The boys live at the colony house, are supervised by an employee and go out to work for private families, stores, etc., at a modest

salary. These boys are beyond the academic school age and are selected for colony placement because of good conduct and ability.

Another type of colony developed at Rome is known as a mixed school colony. Here, both boys and girls under puberty receive academic and manual training, occupational therapy, as well as physical education and supervised games. They are not placed in this colony unless they are sufficiently intelligent to benefit from the training. A matron, assistant matron, academic teacher and occupational therapy instructor make up the personnel.

The girls' colonies under the direction of the Rome, Newark and Syracuse State schools are, with one exception which will be noted subsequently, known as domestic colonies. They are devoted to the care and supervision of patients who work as domestics in the homes of private families in the neighborhood. The girls work out by the hour, day or week and receive about five dollars per week compensation. When working by the week they frequently lodge at the employer's home, returning to the colony house only at week ends. Day and hour workers eat and sleep at the colony. Twelve to 30 girls are placed at each colony. All are over the academic school age of 16. Before going to a domestic colony, however, each girl is given, at the institution, a thorough course in domestic science, learning to cook, bake, clean, launder, iron and sew.

The personnel of each colony house consists of a matron and a cook. The matron takes charge of the money earned by the girls and turns it all over to the institution. Each institution, however, allows each girl some spending money. Generally, about $2 per person per month is forwarded by the school to the colony. Within reason, the girls may spend this money as they see fit. The remainder of the money earned by the girls is used for the benefit of all the patients in the school.

The girls in the domestic colony houses are allowed to go alone to and from work, and may go to the nearby stores if they are accompanied by another girl or an employee. For recreation and amusement they go to the movies, take hikes and have parties at the colony house. In the summer the colony residents move to the vacation house situated on a lake with a good beach, for a week's vacation.

In some colonies, food, clothing and dishes are all bought locally while in others all supplies and equipment are brought from the school.

At the Rome State School, a special type of colony has been set apart for the care and supervision of senile defectives. The administrative setup and the private-home type of colony house are the same as is seen in the other colonies. Most of the old people are patients who have worked hard for years in the working colonies or in the institution proper and who are now no longer able to carry on. They deserve the peace and quiet that is theirs and are contented and appreciative of their good fortune.

For many years several of the State hospitals have been interested in the colony care of mental patients. However, these consisted entirely of farm colonies, no more than one at an institution, located hard by, and only in those hospitals which had considerable farm land under cultivation. These colonies have in most hospitals been considered an integral part of the institution and not as colonies *per se*.

With the exceptions noted above, colony care seems to be most successful with those feebleminded who are capable of working, and even among them, the selection of candidates is definitely limited. *First,* the patients have to be well and strong and able to be up and about. *Second,* they have to be quiet and cooperative as there are no locks or bars on the houses and the supervision is not constant. They must not be elopers. *Third,* they have to be willing to work, to be of use to themselves, the community and the institution. *Fourth,* patients must be fairly intelligent, clean in habits and presentable if they are to work in the community. *Fifth,* girls with a strong sex drive and poor judgment cannot be allowed in the community. Fortunately, with careful selection, it is only occasionally that a colony girl gets into sex difficulties.

For both male and female patients who fall within this limited group, colony life is very satisfactory. It is preferred to life in the institution because there is less congestion and overcrowding, more freedom, recreation, individual care and personal attention. Perhaps the most constructive feature is that the residents are hap-

pier and more self-respecting because they feel they are doing useful work and are worthwhile individuals.

The colonies are a distinct asset from the point of view of the institution as well as the patient. The farm colonies grow large amounts of food and farm produce over and above their own needs and this extra food is sent to the institution. The domestic colonies turn large amounts of money over to the institution and most of this money is used by the institution for the benefit of all of the paients therein.

Family Care

Family care is not new in the care and and supervision of the mentally abnormal. It has been used in connection with European hospitals with excellent results, for more than one hundred years. Probably the best known and most successful family-care unit is the colony of Gheel in Belgium. Smith[1] and Pollock[2] have recently written on this colony. It is so well known that here mention will be made only in regard to its origin. It is not known exactly when or how this colony came into being; but the story, whether legend or fact, as far as can be ascertained, is that an Irish princess, Dymphne, ran away from the home of her cruel, drunken and mentally-deranged father and escaped to Belgium. Incensed, he gave chase, caught up with her, and had her executed at Gheel. This occurred about 600 A. D. Because her life was exemplary, she was sanctified and became the patron saint of the insane, and the Shrine of Saint Dymphne was erected in her honor at Gheel. Persons with mental difficulties began visiting this shrine and gradually the colony of Gheel was established.

For one hundred years or more, patients have been placed in private homes in England and Scotland. However, unlike Gheel, the homes are scattered and the patients placed by local authorities. Because of poor control over the homes, abuses occurred. This condition, however, was corrected by the Mental Treatment Act of 1930, which provided for licensure and inspection of nursing homes by the Ministry of Health. Since this time, these homes have necessarily changed. They now must be under the direction of a psychiatrist and operated by a qualified person, usually a nurse.

At Zürich, Switzerland, Dr. Maier of the Burghölzli Hospital, places patients in family care much like the system of Gheel. This was started by Dr. Bleuler in 1909.

Dr. Kolb of the Mental Hospital in Erlangen, Germany, has placed over 4,000 patients. However, his method is not unlike the parole and discharge of a patient from one of our hospitals.

In Massachusetts, family care was started more than 50 years ago. Dr. Henry W. Stedman, in 1889, made a favorable report on the activities of this type of placement and encouraged its further development. However, little progress has been made as there are now fewer than two hundred patients placed in this manner.

During the past four years, several institutions in New York State have been experimenting with family care. Chief among these is the Newark State School, under the direction of Dr. Charles L. Vaux,[3] who, in 1932, began developing an area in and around Walworth, N. Y., which is patterned after the Gheel Colony. The patients are first admitted to the school, which is about twenty-five miles away, and if they are, after a short residence, found suitable, they are placed with private families. These families are investigated and their homes examined, and of course they have to be found satisfactory before the patients are placed.

There are now more than one hundred patients in this area. Some are very low grade, others idle, old, or semi-crippled, and still others are blind. They get along well, however, if they are cooperative. One family is limited to caring for four patients and receives four dollars a week compensation for each patient. A social worker visits every home each month, and oftener if necessary, and a physician from the school and the medical inspector visit occasionally. A centrally-located house with an intelligent resident matron is used as the community center. Here two beds are reserved so that patients in the area may be sent in because of illness or for some other reason. A local physician is called for medical or surgical emergencies. The community house has a game room with a radio, books and sewing supplies. All patients are made to feel free to visit and use this room to meet patients from other homes at any time, and here, at frequent intervals, parties are arranged by the social worker and the occupational therapist. The

patients' hair and nails receive attention at this center. The school furnishes clothes and 25 cents a week spending money for the patients.

The author has seen and interviewed each of the patients in this settlement and only one was dissatisfied; she had no specific complaints, just disliked everything, and was returned to the school. All the others were very happy and contented, and their faces beamed when they told how much they liked it at the homes. They were really grateful for being there. They are kept clean, have all they want to eat, and are kindly treated. In fact, the families become attached to them and treat them as their own. Walworth is a particularly good community for this purpose, as its members are kind, honest, sympathetic, hard-working, religious people.

During the past year, the State hospitals have been greatly interested in experimenting with family care, and at the present time most of the institutions, except those in the metropolitan area, have a few patients placed out with private families.

Up to July 1, 1936, the Middletown State Hospital had the largest number of patients placed in family care. This placement area is in and around Shavertown, N. Y., which is located in the heart of the mountains, 75 miles northwest of Middletown. It is patterned after Gheel and Walworth. The community appears quite suitable for its purpose as the townspeople are, as in Walworth, honest, hard-working and sympathetic, and poor enough so that the four dollars a week is welcome in the home. The one unfavorable feature is its distance from the institution. The author visited each of these eight homes and talked with each of the 46 patients. They were clean and well nourished, and evidently well treated. Forty-five were happy, contented and even appreciative of their opportunity to be at the homes. One wished to be returned to the hospital and his wish was granted. The members of the families appeared sympathetic toward the patients and friendly toward the hospital. Up to six patients are allowed in each home.

Idle and actively psychotic cases are cared for at this settlement. Those placed include mute catatonic schizophrenics, regressed hallucinated hebephrenic schizophrenics, litigious paranoid schizophrenics and agitated seniles as well as milder seniles, schizo-

phrenics and arteriosclerotics. The patients appear to be giving no undue trouble and the community is adjusting to the patients. It can readily be seen that the problems met with in placing mental patients are more difficult to solve than those associated with placing mental defectives; but it appears that the difficulties are not insuperable and even now are being in part overcome.

Great care should be taken, Vaux cautions, in selecting patients who are suitable and who are certain to cause no trouble, at least until local residents become well accustomed to the idea of having these patients in the community. One serious mistake at the beginning would undoubtedly turn the neighborhood definitely against accepting patients, and news would spread rapidly to surrounding communities and might prevent placement of any patients in the district.

The value of family care depends on whether idle, deteriorated patients who require considerable care and who have always been considered as institutional cases, can be taken out of the institution and placed in the community. If this can be done, a large burden will be lifted from the institution, overcrowding will be diminished, fewer new institutions will have to be constructed, and the acute cases and new admissions will benefit by receiving more study from a relieved staff. This is the hoped-for result, and from the author's observations of the Walworth and Shavertown placement areas, is not impossible of attainment in New York State, since the experiment appears very promising in the up-State rural districts. However, it does not, under present conditions, appear practicable in the metropolitan area. Here the general cost of living, rent and food prices are higher, making it impossible for families to board individuals at four dollars a week. The congested traffic would be dangerous for the patients and because of the proximity of one family to another, patients would attract more attention and perhaps criticism in the neighborhood. In uncongested areas beyond the suburbs some of these difficulties could be avoided, but in such areas residents are mostly persons of private means who would not be interested in caring for patients at any price, as this would interfere with their social and business life.

Provided family care develops as anticipated, it will not only make many patients happier, but will also be of great benefit in reducing overcrowding of the institutions and appreciably lowering State expenditures. For example, the payment of board and room for 4,000 patients in family care at four dollars a week—$208 each a year—would amount to $832,000. This, added to a liberal sum of $300,000* for extra physicians, social workers, occupational therapists, administration costs and incidentals, gives a total of $1,132,-0000. Four thousand patients cared for in an institution at the carefully estimated cost of three dollars a day, including maintenance, construction and administration costs, would be $2,920,000 —more than two and one-half times the cost of family care!

REFERENCES

1. Smith, Philip: Nursing Homes for Mental Patients. PSYCHIATRIC QUARTERLY, Vol. 7, p. 682.
2. Pollock, Horatio M.: Family Care and the Institution Problem. PSYCHIATRIC QUARTERLY, Vol. 7, p. 28.
3. Vaux, Charles L.: New Developments in the Care and Training of Mental Defectives. PSYCHIATRIC QUARTERLY, Vol. 7, p. 672.

*The sum of $300,000 was arrived at in the manner indicated below. The writer appreciates that this is a rough estimate and may require considerable alteration. It was assumed that 10 of the up-State hospitals would be able to place 400 patients each and that the cost of this care would be as follows:

1.	10 experienced full-time physicians	$32,000 00
2.	10 experienced full-time social workers	18,000 00
3.	10 experienced full-time occupational therapists	12,000 00
4.	30 automobiles at $700	21,000 00
5.	Auto upkeep, 30,000 miles each, 10 miles to a gallon, oil and repairs	15,000 00
6.	Administration—10 bookkeepers and 10 stenographers	25,000 00
7.	Spending money ($.25 a week per patient)	1,000 00
8.	Clothing, $25 per patient (In hospital, average cost, $10 per patient)	100,000 00
		$224,000 00

TECHNICAL APPROACHES USED IN THE STUDY AND TREATMENT OF EMOTIONAL PROBLEMS IN CHILDREN*

Part Four: Collective Phantasy

BY J. LOUISE DESPERT, M. D.,
RESIDENT IN PSYCHIATRY, PSYCHIATRIC INSTITUTE AND HOSPITAL, NEW YORK CITY

I. *Introductory*

In three recent papers Potter[1, 2, 3] has ably described methods of therapy in use on the children's service of the Psychiatric Institute. As can be noted, these are individual rather than collective methods, for while group activities (school, occupational therapy, gymnastics) are also extensively carried out, they cannot be considered forms of directed, organized group therapy. On the other hand, some hospitals for various reasons use group in preference to individual therapy. Bender and her coworkers[4, 5] have developed and reported such methods.

That children in a group behave differently than they do as isolated units has been long established. Especially is this apparent if the children are placed under conditions where inhibitions are lifted. Such conditions of course attain in games, provided they are not organized and supervised by adults, and also in games organized by children when no definite rules are to be followed.

Free, non-supervised play fulfills these conditions and many observations have been collected on the free play of children. The reader is referred to the works of Spencer,[6] Karl Groos,[7] G. Stanley Hall,[8] Queyrat,[9] William Stern,[10] Helen Marshall,[11] Susan Isaacs[12] and Griffiths.[13] Free play is very closely related to the expression of phantasy in children, especially the younger children, and every one has seen young children play games such as "house," "school," "cops and robbers," etc., and act their phantasies with convincing earnestness.

In the experiment to be described here, the stimulation of phantasy in a group of children was aimed at, and this when individual

*The author wishes to express her indebtedness to Dr. Clarence O. Cheney and to Dr. L. E. Hinsie for having made this experimental study possible. She also wishes to thank the teacher, Miss Wenz, for her invaluable cooperation; the head nurse, Miss Stein, and the nursing staff, especially those nurses who participated directly in the working out of a project which, by its very nature, exacted resourcefulness, patience, and wisdom in the handling of children.

investigation of the problems of these children was routinely carried out at the same time. The experiment extended from mid-October to the end of December, 1935, and involved all the children on the service, a total of 32—10 girls and 22 boys with chronological ages varying from 6; 10 to 14; 11, and I. Q.'s varying from 70 to 120 (one boy with an I. Q. of 57 was also included). Diagnoses were as follows:

10 *Girls*		22 *Boys*	
Primary behavior disorder	5	Primary behavior disorder	10
Without psychosis—mental defective	1	Psychosis with convulsive disorder	1
Dementia præcox	3	Psychosis with epidemic encephalitis	1
Psychoneurosis	1	Psychosis with meningitis	1
		Without psychosis, chorea	1
		Without psychosis, mental defective	1
		Dementia præcox	4
		Psychoneuroses, psychasthenic	3

There were two definite groups, the boys and the girls.

II. *Description of Technique*

In the case of the first group (boys) the subject for phantasying was suggested by physician, while in the second group (girls) it was left entirely to the children's choice, the reason for this being that the experiment was first carried out with the boys and it was then thought easier to deal with less unknowns.

The suggested project was the "make believe" building of a skyscraper; this was selected for two main reasons: it would be a truly *constructive* project, and New York children would be familiar with the various phases of construction. The stress on the constructiveness factor was brought about by previous observations that the aggressiveness and destructiveness of children are very readily brought out when they are in group and it seemed advisable to avoid introducing any suggestion of a destructive and aggressive nature. If under such conditions the findings were once again pointing toward aggressiveness, at least the type of project could not be made responsible for it.

The children gathered around the physician (later replaced by a nurse, instructed as to the proper handling of the group, and even then with the physician often present); they were informed that all

were going to play a game which consisted in building a skyscraper "not for real." They could express any thought they had about it. No plan was established as to the order in which this building would proceed and it is the children themselves who directed these activities. Since some children, because of their shyness or asocial tendencies, would not participate spontaneously, they were questioned directly as to what they would contribute.

The phantasied building of the skyscraper was carried out in several forms of expression, most of which were spontaneous and some directed and supervised. To the former belong verbal phantasies, dramatic expression, "radio broadcasts," drawings, poems; to the latter belong the compositions written in school and a dance and song project worked out by both the children and the gymnastics teacher.

It must be pointed out that the children themselves evolved the forms of expression listed in the first group and the order of expression is an interesting one. They began by phantasying in words; then gestures and voice expression came in so forcefully that almost without transition drama was created. Then they grouped themselves into working units, with foremen, laborers, etc. They naturally came to the graphic representation and this was done in innumerable forms, small and large sketches, large detailed plans, "blueprints," and finally the poetic expression came up in a rather accidental manner when one boy had unwittingly made up a rhyme. In practice, this sequence was not so strictly followed as given here, and often the children would revert to earlier developed forms. Often these various expressions were (to the adult mind) only distantly related to the original subject, as when a short series of plays centered about a restaurant, presumably in operation in the then unfinished building. How the interest in food, so prominent in all young children's activities, came to explain this anticipated development will be discussed at a later point.

The girls' project was entirely their own, including the subject of phantasy, and in that they were influenced by the coming of Yuletide, since they dramatized, danced, sang, and verbally phantasied about Christmas.

The activities were carried out in the evening in the period between supper and bed time, when no rigid occupation or recreation is ordinarily planned. A stenographic account was taken and it was possible thus to record most of the productions.

III. *Behavior of the Children During the Experiment*

(Boys' group)

As a rule they were productive and showed initiative. The ingeniousness of these children when at free play was very striking. Between 10 and 20 per cent of the boys needed constant encouragement, these being children who were shy, lacking in self-confidence or even occasionally uncooperative.

Several anxious children were at first reluctant to participate but when they did, they promptly displayed an aggressive type of behavior. In the case of four schizophrenic boys, two (Walter H., Miles) could not be interested and were altogether withdrawn and apart from general activities; one (Leonard) cooperated occasionally; the reason for this occasional cooperation was not always intelligible but it usually took the form of sadistic expression. The last boy (Howard) not only would not participate but was antagonistic to questions and indulged in activities altogether foreign to those of the group. When asked what he would contribute, he said, with an air of finality, "Nothing," he kept this attitude throughout and spent a great deal of time printing calendars and innumerable license plate numbers, this representing a major compulsion of his.

The larger percentage of children, always more than two-thirds, were active and aggressive. There were times when the activity and aggressiveness mounted up to general rioting and it was the most taxing demand upon the adult in charge to refrain from interfering up to the danger point. From time to time some children would indulge in side activities such as making flags or reading "funnies," but, generally speaking, it was not very difficult to bring them back to the topic of interest and in fact they became so involved in the skyscraper activities that these would color their thinking and behavior in other fields such as school, O. T. sessions, and even their social exchanges. This mass reaction was

indeed a striking feature of the experiment and probably one characteristic of children as opposed to adults, where suggestibility is not so evident.

Group activity of this sort gives an opportunity to make observations on the type of children who are potential leaders and on the qualities which make for leadership. In our small experience, we have observed the tendency for the more intelligent and aggressive child to take the lead; intelligence alone did not suffice, as shown by the inadequacy of two intelligent boys who did not have enough drive. One boy of 11 years, 9 months (Gerald), with an I. Q. of 120, refused to participate in subordinate positions but on the other hand was quite remarkable as organizer and promoter of new ideas. He stated one evening, "In real life every one doesn't take their turn. One guy is the director all the time. I'll be the director." There was the renewed difficulty of choosing a leader since they would not allow the same boy to take this rôle every day. While it is true that the children appeared successfully to choose their leader, it was also observed that coincidently the leader had to establish himself on his own and if a boy who was eager, or elected, to lead did not have the qualifications he would soon fail. This was the case with three relatively dull, socially inadequate boys who on occasion took an aggressive and important rôle, seemingly overcompensating for their inferiority, living and dramatizing phantasies of power which they otherwise expressed in pathological behavior (lying, stealing) or revealed in individual interviews. There were also two boys (Walter M., Bernard) who, though unable to lead, would interfere as a means of self-assertion, but these were short-lived manifestations, owing to the reactions of the group.

The behavior of the group was striking different from that attaining in other, organized, group activities such as school, O. T., and gymnastics in that it was much more aggressive, due to the release of inhibitory forces.

IV. *Productions*

The most striking single observation bears on the amount of aggression released by this sort of experiment. Apart from a few

statements relative to trivial details (curtain rods, dumbwaiter, etc.) which they mentioned first, the building began in a destructive way, as the children stated they would bring dynamite to "blow the hospital up." While dynamiting is a logical process at the beginning of building, here it was stressed not only at the incipiency of construction, but recurred constantly while the children were building their skyscraper. They would from time to time blow up their imaginary building. This was a fertile subject indeed.

The first play that the children imagined began with a fire and this before any other dramatization was present. A great deal of excitement and confusion took place during which the children would discover a fire and deal with it, and hardly would this one be mastered than another one would arise, etc. Accidents occurred with resulting body injuries of greater or lesser severity. These accidents were of a nature expected in building, such as breaking down of scaffold or crane, but there were also accidents of an extraneous sort such as bullet shots in the course of rioting, or for no apparent reason.

When the question of distributing the jobs came up, many of the children were found striving to obtain the most aggressive positions. A much envied one, for instance, was watchman "because of his gun." Then, when they came to the planning of floors and outlining of their uses, this was again of a destructive nature. Examples of productions by different boys are as follows:

(Bernard) "I'll have machine guns, a few rifles and I'll have some automobiles outside." . . . "I have a machine gun business up there," to which another boy answers, "I am going to blow it up." (Julius) "My friends are going to bring a cannon." (Harvey) "I am going to have my army uniform on the wall and army rifles and machine guns." (Daniel) "Laboratories where they experiment with bugs, and dynamite for other buildings—dynamite room where they experiment to make dynamite." (Frank) "My rooms are going to be all cannons, machine guns and bullets . . . I am going to make a war." One could multiply such examples. Another boy was much interested in a skeleton he said he found in the ground as he dug for the foundations. Frequently, aggressiveness was expressed with anxiety. "Skyscrapers are very dangerous.

Millions of people get killed . . ." One boy stated that everybody should carry first aid kits in anticipation of possible accidents. One of the boys chose to build what he called "a skyscraper prison" and his numerous drawings and other phantasies served as vehicle for the expression of anxiety related to guilt.

Phantasies of power were commonly expressed, as when it was suggested that a 120-story skyscraper be built, or that two whole blocks would be covered by this construction. Another suggested a building plot of 395 feet, while one boy even stated, "It is going to cover the whole world." They described their project as "the biggest skyscraper in existence."

An interesting though limited aspect of the mental productions was the *expression of phantasy in relation to individual problems.* Bernard, who has been referred to in previous publications (See PSYCHIATRIC QUARTERLY, April, 1937) wants to "drive a truck and bring the sand," and this is referring to his fear of being run over by a truck and so killed. This boy also brought out the identification with his father when he described that he wanted to be a night watchman and made a drawing of a gigantic gun he was to carry. (His father actually is a night watchman in a building under construction.) Another boy (Julius) wants in turn to build a "skyscraper for sick people, for people who are sick and they get well," and a skyscraper prison. His anxiety, alluded to previously, is further expressed by his instituting severe punishment of prisoners at the hands of the guards. Some of his productions in relation to the skyscraper are as follows, "It's a skyscraper prison, the man at the door is a guard with a big gun; in the middle where there are prisoners, there are no windows or doors for them to get out; the aeroplane (pictured in his drawings) is dropping things to them to eat." He also adds that the skyscraper will be "near the water and they can shut the iron gates so that water can't come in." In the play that this boy directed, all the drama revolved about the guilt theme which is the prominent feature of his problem. This play consisted in the sudden irruption of a gangster in the midst of a family with a large number of children (corresponding to his own family, of which he is the "black sheep"). Julius gave himself a heroic rôle, revealing the identity of the

gangsters and murderers, "chasing" them and finally "slaying" them. Following this, however, the gangsters were revived in some mysterious way and the gang war was ready to start all over again. One boy (Hugh) whose main problem is related to uncertainty with regard to his own identity (he was abandoned by his mother and adopted at a very early age by a domineering and unreliable foster mother who brought him up) phantasied that he was a nobleman and concerned himself with changes in social station and position.

Aside from the few cases where the motivation of the phantasy was very closely and adequately related to the individual problem, this mode of collective phantasying showed no specificity, that is, while aggressive trends or guilt or anxiety found a means of expression in a broad, general way, this expression was not, as a rule, so particularized as is the case with individual methods of approach.

Two boys expressed self-destructive tendencies when one (Bernard) called upon to be director of the play one evening, suggested, "Can I have a suicide play? No? Well, can I have an accident play, then?" while another (Walter) announced, "I am committing suicide," in a phantasied aeroplane trip which started from the top of the skyscraper. In the first case, the expression of self-destruction was interpreted as an attempt to deal in phantasy with a real problem of anxiety. This mechanism has been described in previous writings as one by which the child strives to overcome fear by verbalizing it in phantasy form and working through its affect, i. e., abreacting it. In the second case, the suicidal trends were considered an expression of aggressiveness deviated from its initial object, the interpretation being based, in both cases, upon numerous expressions of phantasy either by means of this project, or as a result of individual investigation by other means in use (drawings, stories, etc.)

Food themes were widely elaborated upon in the course of several plays taking place in a restaurant. It is interesting to note that in these particular plays the most active children were four boys, three of whom were severe compulsives. While the productions themselves were not specifically orally aggressive, it is worth noting that coincident with the eating there was a great deal of

rioting so that it is reasonable to assume a relation between the oral activities on the one hand and the aggressiveness on the other.

A fairly large amount of interest crystallized at the anal level, very early in the development of this project. This was brought out by a compulsive boy who at the beginning of the second meeting, after some one had stated, "We got the walls, but we haven't got the roof," shouted, "We forgot the toilet bowls!" Another boy stated after the mention of laboratories was made: "He is interested in bowels . . . that's why he wants a lot of laboratories (the obvious meaning is now lavatories) . . . they are used to sleep in and move their bowels in." This boy made several drawings of what he called "bowels," figures which were obviously in the color and shape of feces.

Some material was brought out in an apparently irrelevant fashion. This was a rule brought by clang associations. It is noteworthy that the boys who expressed these were the less intelligent boys as well as the most suggestible.

The discrepancy between reality and phantasy was clearly brought out when the children approached the problem of the costs of their imaginary building; when one boy sated that he wanted steel, the one in charge of materials told him it would cost $10 and the skyscraper which was to be "the tallest in existence" would altogether cost about $200. The damages collected for the various fires, however, made up for these unexpectedly low prices and usually large amounts running into the thousands would be collected for them.

V. *Further Developments*

As stated previously, these children did not confine themselves to verbal phantasy but elaborated numerous plays, a few of which were related directly to the building while the majority were only remotely connected with it. Restaurant scenes, wars, "Dick Tracy" episodes, cowboy exploits, Indian wars were the favorite subjects. Curiously enough, the children did not seem to have any awareness that they were departing very much from the initial project. In their minds, all of these productions were at the outset related to the collective phantasy venture. Drawings were numerous and

varied; generally they were concerned with phantastic material, but there was also a small number of drawings realistically descriptive of implements and machinery used in the phantasied building.

Comparing these various forms of expression, it is noted that there is a great deal more freedom in the verbal phantasies, drama, and drawings. It is in these activities that the *motor* factor is more prominent and since the child is generally found more productive and spontaneous when he is given a chance for motor expression, it is possible that here lies the explanation.

Another finding which was very illuminating was that the "formal" productions (compositions and poems written in school, also assignments given during rest hour) reflected inhibition; such productions were scant and free from expressions of aggressiveness. To illustrate, the following compositions written in class by two of the most aggressive children, (as ascertained by their behavior during collective phantasy experiment and spontaneous productions during interviews), are cited:

> (Bernard) "OUR SKYSCRAPER . . . We have all these things in the skyscraper, a boiler, a heating system, a clock, bulbs, switches, and door locks. It is up to the first floor. I am the cop."
>
> (William) "OUR SKYSCRAPER . . . We have all these materials, cement, metals, beams, glass and wood. I do not know how far the construction is. The workmen we have picked are electricians, plumbers, excavators, carpenters and many other workmen. I help the secretary."

During the collective phantasy project, the first of these boys was constantly expounding on killing, and other forms of aggression; he also suggested the "suicide" play: while the second boy phantasied "millions of people killed," etc. These observations are the more striking since our school teacher is a kindly, sympathetic, intuitive woman with whom the children have a good rapport, and inhibition is probably at a minimum in the child-teacher relation, where she is concerned.

The repercussion that this collective experiment had outside of the periods during which it was carried out is best summed up by a report made by the school teacher at that time. "Although the skyscraper project was an outside activity, it had a direct influence

on certain particular children and on the group as a whole. It also indirectly influenced the academic work in the classroom. The group as a whole became more cooperative, helpful, and tolerant toward each other. They showed greater interest and skill in handling other projects. In their spare time instead of not knowing what to do, the children have asked for permission to construct and to draw things. The whole class was willing to write for long periods when asked to write songs about the skyscraper. The children have also increased their vocabulary considerably and have gained a specific knowledge of general facts. As a result, some of the poor readers are making use of the class library. Two of the discipline problems (Bernard and Walter) have been easier to handle. They are both very imaginative and their attention can be easily diverted if asked to draw, construct and play something in connection with their skyscraper."

VI. *Differences Between Boys and Girls*

It seems unnecessary to go into the girls' experiment at length; thus merely the essential differences between the reactions of boys and girls will be discussed here. It will be recalled that the girls labeled their project "Santa Claus."

While aggression was expressed by some of the girls, it was to a lesser degree, at least in so far as direct expression is concerned (direct verbal and motor expression.) There were only two such girls and one of them asked if Santa Claus carried guns, while the other verbalized an inordinate amount of aggression and even cannibalism. This last child (Arlene), as studied individually, revealed a wealth of oral sadistic phantasies and this was quite in keeping with her general pattern. An example of her productions at this time is as follows: "I'll cut everybody's head up, and you, I'll cut your whole body up and eat you up for supper." (You know I'm an old lady, and I'm too tough to eat.) "But I'll have a lot of bones to suck on, and juice."

Whenever expressed by one child, aggression did not seem to be communicated to the group so readily as was the case with the boys and thus remained in the form of individual and isolated responses.

As a consequence, it seemed that the release of tension was less readily accomplished.

Phantasies in specific relation to individual problems were expressed by four of the girls; one of the many examples of this is seen in the remark made by a child of nine (Rosalind), who indulged in pregnancy phantasies and once stated during the experiment, "I want to be Santa Claus because I want to be plump here and fat (points to her waist). If I'm not fat I could put a pillow there."

The girls, at least in this small experiment, showed themselves to be less imaginative, by referring more to actual happenings and past and domestic experiences than to a world of make believe. How this should be interpreted is not apparent; whether it represents a lesser ability to phantasy or a greater inhibition exerted over phantasies which are present. The latter might be the result of early training and this point will be taken up again.

The whole performance in so far as the girls were concerned, gave more of an impression of organization and conscious expression than was the case with the boys.

VII. *Summary and Discussion*

The collective phantasy experiment provides a motor outlet as can be seen by the marked activity displayed during the sessions. Children identify themselves with the personages they phantasy, and consequently live through the emotions which they attribute to these personages. This is of course of some importance in a setup which does not provide an outdoor playground where children could freely exercise their impulses and work off their pent-up energy.

It also provides an outlet for the release of impulses which, as can be judged by previous accounts, were almost entirely aggressive. Although starting from a constructive theme, the stress was not upon construction but upon destruction, and it seems that the building-up served almost entirely as a means of destroying again. Whether this would be so with a group of normal children can only be a matter of speculation until the experiment is repeated with a group of normals. However, Susan Isaacs,[14] working with a group

of children of kindergarten age, writes: "Probably the first thing that struck readers about this part of the material (social relations) was the sheer amount of spontaneous aggression in such small children, coming from good homes where most of them had of course been taught from an early age to be 'kind' and polite."

Generally, the released aggression is non-specific as opposed to that obtained by individual methods. Consequently, collective phantasy has relatively little value from the point of view of investigation; neither does it offer a specific means for the child to gain insight into his own deeper motivation. On the other hand, it is an excellent means of abreaction.

Imitation and suggestibility play an important rôle in this collective experience. One must beware of attributing to the individual child affect and content which are not necessarily deeply a part of his own reaction patterns. Susan Isaacs, after long and penetrating observation of a large group of children writes (op. cit., p. 388) "Much of the behavior of this group of small children could be described as 'herd' behavior . . . but the parallel gives us no insight into the meaning of such behavior for the individual children who made up the group and is quite specious and misleading." Whether suggestibility is more marked with our children than with a group of normals is again a question that could be answered only by a comparative study of a group of normals of the same ages, social status, etc.

This experiment provides an opportunity for the release of exhibitionistic trends without fear of censorship.

It brings out also two facts long known: (1) the capacity for children to make their phantasies into concrete realities, and (2) the ever-renewed pleasure a child gains from repeating a game and living over and over the affect tied up with the game, without apparent weariness.

That, in a play group, girls are less aggressive than boys is a matter of general observation, whether one deals with normal or mentally-ill children, which does not prevent some girls from revealing just as much aggressiveness in individual expression. Helen Marshall[15] has suggested that while the adopting of different modes of training, may, in the future, reduce the sex differences, "at least

a part of the difference is inherent and real." Griffiths[16] has shown that there are differences between boys and girls, as regards their interests, that these color their phantasy life and are revealed in their imaginative play. She writes: "the boys are, for the most part, interested in matters outside the home—the little girls at 5 years—are veritable little mothers." These differences were clearly illustrated by the productions of our children.

That girls as a group appear also less imaginative may be due only to the fact that they are more inhibited, and consequently hindered in their phantasy expression. We find no enlightenment on this point either in Isaacs or Griffiths since these authors study the phantasy expression of aggressiveness without regard to sex differences. It is interesting to note that, among our girls, the two who formulated aggressive phantasies were those with the richest phantasy life and the highest I. Q.'s. This, together with several similar observations on the boys, makes one feel that the problem of aggressiveness is in some way related to the problem of creativeness.

The presence of the physician (or adult in charge) brings up a point of capital importance, namely, his attitude. In their dramatic play, when they are unhindered and think themselves unobserved, children express freely impulses which, very early, members of the social group attempt to curb. Playmates, unless they are much older and already looked upon as censors, are not considered instruments of repression; they *participate*. It seems to us that the primary attitude required of the physician in this or other approaches, is that *of participation,* in the literal sense of the word. The child under investigation or treatment must feel that the physician is not only sympathetic, but also that he is capable of entering his world and apprehending its different values. Censorship is only one of the ways by which the child recognizes that the adult does not participate, but there are other ways, too inquisitive or suggestive questions, too insistent references to his actual "faults," requests for obedience, unsympathetic tone, lack of interest, etc., which the child interprets as danger signals, and which prevent the release of conflict tension. We know that at the hospital the early

family situations are reproduced; often by his very position in the hospital constellation, the adult is prevented from realizing this participation. However, all the efforts of the therapist must tend toward it. The striking differences between productions obtained by different adults point the way to the type of approach which is valid and efficacious—formalized answers throw no light on the nature of the child's conflict even when the personality of the adult is, as was the case with the teacher, the prototype of the "good parent." The amazing spontaneity of children's expression in certain study groups where adults have adopted the attitude described as one of participation (for instance at the Malting House School for young children, or the London and Brisbane schools, or La Maison des Petits where Isaacs, Griffiths and Piaget respectively made their observations) is a most fruitful source of information, as regards the understanding of the inner world of childhood.

It can readily be seen also that, passing from free, nonsupervised play to directed, supervised expression has a socializing effect on the individuals in the group and, although it is the most difficult phase of this collective activity, it should be attempted.

To conclude, the following quotation from Susan Isaacs summarizes adequately the rôle of free dramatic play: "Psychoanalytic studies of little children, moreover, have also shown that, in their dramatic play, children work out their conflicts in an external field, thus lessening the pressure of the conflict, and diminishing guilt and anxiety. Such a lessening of inner tension through dramatic representation makes it easier for the child to control his real behavior, and to accept the limitations of the real world."

REFERENCES

1. Potter, H. W.: A service for children in a psychiatric hospital. PSYCH. QUART., 8, 16-33, 1934.
2. Potter, H. W.: Psychotherapy in children. PSYCH. QUART., 9, 335-347, 1935.
3. Potter, H. W.: The treatment of problem children in a psychiatric hospital. Amer. J. Psychiat., Jan., 1935, 869-880.
4. Bender, Lauretta: Group activities on a children's ward as methods of psychotherapy. Amer. J. Psychiat., Mar., 1937, pp. 1150-1173.
5. Bender, L., and Woltmann: Use of puppet shows as psychotherapeutic methods for behavior problems in children. Amer. J. of Orthopsychiat., 6: 341-354, July, 1936.
6. Spencer: Principles of Psychology, II Pt., VIII. Chap. 9, 2 Vol., London, 1872.
7. Groos, Karl: Play of Animals. Trans. by E. L. and J. N. Baldwin. D. Appleton Co., N. Y., 1898. P. 341. Play of Man. Trans. by J. N. Baldwin. D. Appleton Co., N. Y., 1901. P. 412.

8. Hall, G. Stanley: Aspects of Child Life and Education. Athenaeum Press, Ginn Co., Boston, 1907.

9. Queyrat, Les jeux des enfants. Paris, 1905.

10. Stern, Wm.: Psychology of Early Childhood. Chap. on Play.

11. Marshall, Helen: Children's plays, games and amusements. Chap. XV, Textbook of Child Psychology, edited by Carl Murchison. Pp. 515-526.

12. Isaacs, Susan: Social Development in Young Children. Routledge and Sons, London, 1933, pp. xii+480.

13. Griffiths, Ruth: Imagination in Early Childhood. Keegan Paul, London, 1935, pp. 367 Chap. 17, Play, pp. 318-329.

14. Isaacs, Susan: Cf. Ref. No. 12, p. 218.

15. Marshall, Helen: Cf. Ref. No. 11, p. 523.

16. Griffiths, Ruth: Cf. Ref. No. 13, p. 323.

PATIENTS' OBSERVATIONS ON CARE AND TREATMENT

Made on Leaving a State Hospital

BY NEIL D. BLACK, M. D.,
SENIOR ASSISTANT PHYSICIAN, MARCY STATE HOSPITAL, MARCY, N. Y.

Through experience certain methods of treatment have been developed in the State hospitals which are believed to be beneficial. What does the patient himself think about them? Most of our knowledge as to what has been helpful has been gained from a retrospective view of the whole period of illness as related by the patient himself. Steckel[1] compiled a questionnaire consisting of 23 questions which he asked 34 recovered manic-depressive patients. He concluded that the replies received were so generalized that he found the study, while interesting, rather disappointing. An individual approach, but from a different angle, has been carried out at the Marcy State Hospital, through a questionnaire which consisted of 14 questions. This questionnaire was presented to a group of one hundred patients shortly before their parole or discharge and they were asked to be perfectful frank in their answers and to make any criticisms which they felt were justifiable. No assistance was given to them. The purpose was to obtain from the patient himself his reaction toward the care and treatment he had received, and to ascertain if possible from his replies in what way our system might be modified to better meet his needs.

In a survey of this kind there are two rather obvious questions that come to mind: 1. Does a survey of this type have a definite value? 2. Can we rely on the answers as submitted by our patients? The answer to the first question may well be in the affirmative. In the second there may be a reasonable doubt in some instances, since the accuracy of observations is in proportion to the insight the patient has gained. In the forthcoming pages elaboration will be made and conclusions drawn.

The exact wording of the questions, and a summary or replies will be found on pages 512 through 516.

Question 1. In the PSYCHIATRIC QUARTERLY for October, 1934, appears an article entitled "The Value of an Orientation Letter for

Newly-Admitted Patients.'"[2] The proposed orientation letter was presented to one hundred newly-admitted patients and the authors felt that it was understood completely or in part by 69 of them. With the same thought in mind, a similar sheet was compiled at this hospital. Seventy-seven patients received the sheet, 69 found it helpful.

Question 2. That hydrotherapy is of distinct value there is little doubt. Observations over many years indicate this. Its use is ever widening in scope. The type of hydrotherapy prescribed, whether it be stimulative, eliminative or sedative naturally is determined by the type of case to be treated. Certainly in depressed cases the tonic and stimulative types intensify the bodily functions and elevate the emotions of the patient. Elimination of waste products and toxins undoubtedly makes the patient feel better and improves his condition. Sedative types by their soothing effect and the relief of tension, restlessness and fatigue are also of undoubted value. There is in addition a decided psychic effect on the individual which is very important. That the patient in many instances felt that this treatment was helpful is shown by the answers. Out of 81 receiving this treatment, 80, or 98.8 per cent, felt that it had helped them.

Question 3. We are all keenly aware of the various attitudes which patients assume toward those they consider to be in positions of authority; during the more acute phases of a psychosis the feeling is frequently one of resentment and antagonism. Our efforts have been directed toward a correction of this attitude. The personality of the physicians and nurses and their attitude toward the patient are of much value. What do the patients themselves think of us? Evidently that we are doing a good job, as 94 report that they have been benefited by these contacts.

Question 4. There is more truth than poetry in the saying "The devil finds work for idle hands to do," but this work unfortunately is not constructive in nature. The impossibility of giving every patient the exact type of work for which he is best fitted is no cause that he should not be kept occupied. Even the simplest of tasks requires a certain degree of mental effort and this effort leads him in the direction of reality, which is the ultimate goal. The

fact that something accomplished is something gained must not be lost sight of as it gives the patient a sense of self-satisfaction. Ninety-one felt that the occupation assigned had been helpful.

Question 5. While diet of itself cannot be considered a psychotherapeutic measure, yet it warrants careful consideration. It has been said that "an army travels on its stomach." So do we all, and even more so those who have become in any way incapacitated. Building up the physical reserve of the individual in many instances tends also to build up his mental reserve. In any large institution where a careful budget is required the problem arises of meeting individual needs. It is felt that this situation has been met. Apparently our patients feel the same way about it, as 97 indicated that their diet had been adequate. The main criticisms were "not properly balanced" and "scarcity of fresh vegetables." Two patients spoke of the former and three of the latter.

Question 6. All who have dealt with mental hygiene problems are well aware of the value to the patient of association with others. Generally speaking, the more severe the mental abnormality the more the individual desires to remain by himself. How often relatives say to us, "John prefers to be by himself. Is it not possible for him to have a private room as he is irritated by those about him?" They do not realize as we do that through their kindly interest they propose doing the very worst thing possible for the patient. What do the answers to this question tend to show as to the patients' own feelings in this matter? Eighty-nine stated that they felt friendly towards and interested in other patients. Seventy-eight felt that the contacts they had made with other patients had been helpful to them.

Question 7. From our knowledge and observations of mental disorders it has been felt that the patient's association with those more afflicted than him has not always been to his detriment. In all institutions every facility is used to classify patients as to the severity of their mental disorders and their reactions. This ideal however is very difficult of attainment. Our classification is at times criticized by the individual patient but more frequently by interested relatives. The patient's improvement in many instances may take place through contrast and the realization on his part

that others may have a heavier cross to bear than he. That patients are as a rule not adversely affected by their associates is well brought out by the fact that 73 felt that their associates had helped them, 10 felt that they had not been helped by such contacts, 11 were doubtful and only 5 felt that they had been made worse.

Question 8. In this present age of hurry and bustle we frequently do not find time to do many of the things which are beneficial to us. Exercise within one's capacity is known to be beneficial. When those of normal mind tend to become disinterested as to bodily needs, how much more so does the individual become who is essentially absorbed in self and who frequently uses this very absorption as a reason for not entering into healthful activities. There is more benefit in the walking party than the physical relief which accrues from the exercise alone. It takes the patient away from his actual ward or building, gives him the advantage of a certain degree of freedom in the fresh air, gets him over that "cooped up" feeling, broadens his interests and outlook and tends to take his mind away from himself and to divert his interests to actual occurrences about him. That these walking parties are appreciated and are beneficial is brought out by the patients' expressions on this point—88 appreciated them and found them helpful. This number would probably have been larger had we been able to take into consideration the seven who were physically unable to participate in this activity.

Question 9. Besides various forms of occupation we have recreation. An evaluation along this line would appear to be of interest. There is a familiar quotation, "All work and no play makes Jack a dull boy." We are all aware of the homely truth evidenced in this quotation. Why then should we consider our patients as different from ourselves? It does not appear logical that we would be justified in so doing. Observations would tend to show that of the two, regular occupation was more desirable and the more fruitful field. What did our patients feel about this? It would appear that they concurred. Sixty-eight preferred occupation and only 10 recreation; 14 answered this question by the word "both," which of course does not permit comparison. As in other State hospitals we are limited as to types of occupation which will

appeal to the individual and this probably explains why more accurate observations were not made by our patients on the type of work to which they had been assigned. Forty-seven felt the occupation provided to be best suited their needs. Six answered this question in the negative and 47 did not answer.

Question 10. Psychotic patients before their admission to a hospital have been more or less in conflict with their environment. Those with whom they have been associated may or may not appreciate that a change has taken place in their personalities. They are apt, therefore, to blame the patient, not realizing that the traits evidenced are abnormal and not within his control. Censure by them only drives him further away and creates difficulty after difficulty. A marked and often rapid change in the individual's behavior occurring shortly after his hospitalization is frequently noted; this is often due to the belief on his part that he has obtained immunity or relief from his difficulties, not having transferred them to his new environment. Certainly we can say this in favor of the hospital—that the patient is in an understanding and helpful environment, protected and guarded from stresses and strains and that he is under a kindly but regular régime. Is this environment of itself helpful? It is believed so. What do our patients say? Eighty found hospitalization beneficial to them; 16 not beneficial.

Question 11. With all the forces that have been brought to bear upon the patient during his hospitalization we find a decided improvement in his mental condition, particularly in regard to the new adjustments he has been required to make. Has this stabilized him? The replies of the patients seem to indicate that their adjustments to hospital life have fortified them in some manner against the complexities of society. True, this training has been in a protected and scientific environment but has been directed toward the placing of more individual responsibility. Much of this training and experience will remain when taking up responsibilities at home. He may also have learned what to avoid as well as what to seek in keeping a proper mental balance. How did the patients feel about themselves and the future? Ninety-one felt that they understood themselves better and would be able to make a better adjustment. Seven did not.

Question 12. Naturally we have studied carefully the patient's condition and his chances of getting along in the community prior to his leaving the hospital. An improvement must have taken place if we are to hope that he will make an adjustment. It is of value, however, to know what his own evaluation of his condition is. Ninety-five felt their condition was improved; five not improved.

Question 13. When considering walking parties we spoke of the value to the patient of getting away from his immediate surroundings and in this way gain an added incentive to make new contacts. This is also to a certain extent true of occupation. In certain instances a patient would appear to improve more rapidly when given employment in another department. It was thought, however, that regular employment rather than the actual place of employment was the more beneficial. Wholesome surroundings proved to be a distinct asset, work also had to be varied in order to meet the patient's needs. What did the patients feel with regard to the location of their employment? Sixty-one designated their own building. Twenty said other departments. Four were doubtful on this subject.

Question 14. In the evaluation of what has been helpful we have always been interested in getting a retrospective account of his treatment from the patient himself. We find that the majority are not able to pick out any one distinctive feature but feel that it is a combination of many. Thirty-seven fell in this group. A few of the more outstanding observations as brought out by this survey are mentioned: hydrotherapy and lamp treatment, 13; association with others, 14; a combination of hydrotherapy, lamp treatment and association, 7.

Summary of Replies to Questionnaire

***Question No.* 1.** Do you feel that the information sheet given to you on admission was helpful in your adjustment to hospital life?

Answer		
(a)	Admitted before date of issue	21
(b)	Receiving sheet and finding it helpful	69
(c)	Receiving sheet and finding it not helpful	5
(d)	Did not answer this question	3
(e)	Too upset to comprehend nature of sheet	2
		100

Question No. 2.

A. Have you received hydrotherapy or special lamp treatment?

Answer

(a)	Yes	81
(b)	No	18
(c)	Not answered	1
		100

B. Do you feel that this has benefited you?

Answer

(a)	Yes	80
(b)	No	1
(c)	Did not receive this treatment	18
(d)	Not answered	1
		100

Question No. 3. Have your associations and interviews with physicians and nurses benefited you?

Answer

(a)	Yes	94
(b)	No	4
(c)	Doubtful	1
(d)	Not answered	1
		100

Question No. 4. Do you feel that the occupation to which you have been assigned has benefited you in any way?

Answer

(a)	Yes	91
(b)	No	1
(c)	Physically unable	5
(d)	Uncooperative	1
(e)	Not answered	2
		100

Question No. 5. Has your diet been adequate? If not, how might it have been improved?

Answer

(a)	Diet adequate	97
(b)	Diet not adequate	3
		100

Suggestions and criticisms

Not suitable for an invalid	1
Scarcity of fresh vegetables	3
Better service of diets	1
Not properly balanced	2
Improperly cooked and insufficient	1

Question No. 6. Naturally divides itself into three sections.

I. How have you felt toward other patients with whom you have been associated?

Answer

(a)	Friendly	89
(b)	Not interested	2
(c)	Not answered	9
		100

II. Have any of them helped you in getting well?

Answer

(a)	Helpful	78
(b)	Not helpful	14
(c)	Not answered	8
		100

III. If so, in what way?

Answer

(a)	General association		75
	Subgrouping		
	Association	58	
	Kindness	2	
	Discussion	5	
	Encouragement	7	
	Comparison	3	
(b)	Not answered		15
(c)	Not helped		10
			100

Question No. 7. Do you feel that association with other patients who are more upset than you has helped you to realize your own condition or has it tended to make you worse?

Answer

(a)	Helpful	73
(b)	Not helpful	10
(c)	Doubtful	11
(d)	Worse	5
(e)	Not answered	1
		100

Question No. 8. Do you feel that regular walking parties and exercise as carried on at the hospital have been beneficial to you?

Answer

(a)	Helpful	88
(b)	Not helpful	2
(c)	Uncooperative	1
(d)	Physically unable	7
(e)	Not answered	2
		100

Question No. 9. Naturally divides itself into two sections.

I. Which do you feel has been more helpful to you—recreation or regular occupation?

Answer

(a)	Occupation	68
(b)	Recreation	10
(c)	Both	14
(d)	Uncooperative	1
(e)	Physically unable	3
(f)	Not answered	4
		100

II. Have you been assigned to the occupation which most suits your need?

Answer

(a)	Yes	47
(b)	No	6
(c)	Not answered	47
		100

Question No. 10. Has the regulated régime at the hospital with its freedom from stresses and strains of the home benefited you in any way?

Answer

(a)	Beneficial	80
(b)	Not beneficial	16
(c)	Doubtful	1
(d)	Not answered	3
		100

Question No. 11. Do you feel that through our efforts at the hospital you now understand yourself better and will be able to adjust to those circumstances which formerly caused you to become upset?

Answer

(a)	Yes	91
(b)	No	7
(c)	Not answered	2
		100

Question No. 12. Do you feel that your condition is now better or worse than on your admission to the hospital, and in what way?

Answer

(a)	Improved	95
(b)	Not improved	5
(c)	Worse	0
		100

Question No. 13. Which do you feel would have been more beneficial to you—employment in your own building or in some other department of the hospital?

Answer		
(a)	Own building	61
(b)	Other department	20
(c)	Doubtful	4
(d)	Physically unable	3
(e)	Not answered	12
		100

Question No. 14. Is there anything outstanding either in your treatment or association with others that has helped you?

Answer		
(a)	No outstanding features	37
(b)	Surgical operation	2
(c)	Interviews with physicians and nurses	4
(d)	Interviews with physicians	2
(e)	Massage and association with others	1
(f)	Hydrotherapy and lamp treatment	13
(g)	Malaria and other antiluetic treatment	4
(h)	Realizing others worse	1
(i)	Routine and regularity	5
(j)	Friendly attitude	4
(k)	Association with others	14
(l)	Hydrotherapy, lamp treatment and association	7
(m)	Contrast of condition with others	1
(n)	Treatment more than association with others	1
(o)	Not answered	4
		100

Conclusion

It is believed that this survey has been distinctly worth while. Though it does not bring forth anything that is particularly new, it does evidence certain lines of procedure which have been decidedly more helpful than others and on which special emphasis should be laid. It has focussed on certain features of everyday care and treatment. It has been helpful in arranging and planning schedules that more adequately meet the needs, and fit in with the aptitudes and interests of patients.

References

1. Steckel, Harry A.: Retrospective evaluation of therapy. Psychiatric Quarterly, Vol. 8, No. 3, pp. 489-498.
2. Dembo, Tamara and Hanfmann, Eugenia: The value of an orientation letter for newly-admitted patients. Psychiatric Quarterly, Vol. 8, No. 4, pp. 703-721.

BOOK REVIEWS

Measuring Intelligence. A Guide to the Administration of the New Revised Stanford-Binet Tests of Intelligence. By LEWIS M. TERMAN and MAUD A. MERRILL. Houghton Mifflin Company, New York, 1937. Text, 71 pages; test material, 340 pages; appendix and index. Price $3.00.

Terman and his associates have expended great effort in this, the second revision of the Binet-Simon intelligence scale. The worth of the first Stanford revision having been amply demonstrated by its widespread clinical use, a thoroughgoing study of its shortcomings was begun 10 years ago; the present revised scales are evidence that no stone has been left unturned to produce a manifestly reliable instrument of psychology. The success of the venture cannot be doubted, and there is an admirable restraint in the following statement found in the preface: "We do not flatter ourselves that we have been entirely successful, but our data represent a much closer approximation to an unbiased sampling than has heretofore been attained in the standardization of any scale for individual examining."

Not the least effective weapon in any struggle for knowledge is a readiness to recognize earlier inadequacies. The authors of these scales are not deficient in this quality, since they frankly admit to five major faults in the older Stanford revision. Probably the most significant accomplishment in the newer work is the provision of parallel scales, called form L and form M; these two scales differ almost completely in content, but are mutually equivalent with respect to difficulty, range, reliability and validity. In general, both are somewhat less verbal than the old scale, particularly in the lower year levels.

Greater specificity of testing at certain age levels has been achieved by furnishing an increased number of tests. Each of the forms, L and M, contains 129 tests. The advantage deriving from this expansion of material is described thus: "Below the five-year level tests are now located at half-year intervals; the gaps which existed at years 11 and 13 have been filled and the scale has been given more top by the addition of two supplementary superior adult levels."

Particularly instructive are the remarks on adherence to standard procedure. Long usage of these tests has brought out certain desiderata of practice that tend to enhance standardization. For example, the ideal administrator of the tests is conceived of as one who, while not susceptible to uncontrolled emotional responses to the subject, nevertheless is capable

of meting out encouragement in such a way as not to injure the objectivity of the examination. The authors say, "In praising poor performances of older subjects, the examiner should remember that the purpose of commendation is to insure confidence and not to reconcile the subject to an inferior level of response;" also: " . . . Praise should never be given between the items of a test, but should be reserved for the end of the test."

A frequently encountered objection to large portions of the scale has been the verbal character of the problems. Terman has said, "Like other investigators, we have found that it is extremely difficult to devise non-verbal tests for the upper levels which satisfy the requirements of validity, reliability and time economy . . . At these levels the major intellectual differences between subjects reduce largely to differences in the ability to do conceptual thinking. Language essentially is the shorthand of the higher thought processes, and the level at which this shorthand functions is one of the most important determinants of the level of the processes themselves." Reminiscent, indeed, of the words "thinking is merely talking to oneself," but not too great a generalization to have in it far more than the germ of truth.

The work of Terman and his assistants can be highly commended, instructions for administration of the tests are most welcome, and it is anticipated that more accurate knowledge than ever before will be obtained in the field of intellectual measurement.

Yoga. A Scientific Evaluation. By Kovoor T. Beharan, Ph.D. The Macmillan Company, New York, 1937. 249 pages, glossary and index. Price $2.50.

When Francis Bret Harte wrote, "That for ways that are dark and for tricks that are vain, the heathen Chinese is peculiar," he was echoing the occidental's popular conception of life and thought throughout the East. The average representative of western civilization wishes fervently to learn "what is behind that 'rope trick'" but he evinces far less interest in the fact that yoga goes much deeper into the springs of life than medicine-show magic. He is furthermore blissfully unaware that the yogins have a system of living which not only offers a sense of well being that is a far cry from the dizzy pace of life in the western world, but which is based upon an understanding of the bodily organs, and means for their development.

By virtue of its broad compass in comparatively small space, the book under review merits a thorough reading. An instructive chapter opens with the discussion of the rôle played by the yogic school in the pattern of Indian culture; Indian culture itself is also briefly outlined. Subsequent chapters take the reader deeper and deeper into the basic concepts of yoga.

Of particular note to psychiatry is Chapter VIII, "Yoga and Psychoanalysis," in which both are described as therapeutic systems. The concept of the unconscious is shown to be common to both schools of thought; the requirement of psychoanalysis that patients must be prompted by their own suffering to seek treatment has its counterpart in yoga. Similarly, there are other elements of theory and of practice in which psychoanalysis and yoga bear close resemblances. The author does not, however, give himself over to naïve enthusiasm for the thesis of resemblance, for sharp differences are also demonstrated. The most vital of the dissimilarities is discussed on pages 163-164, thus:

> In conclusion it might be pointed out that therapeutic similarities exist between psychoanalysis and only the earlier phases of yoga. The higher states of yoga are reached by psychophysical and mental exercises for which psychoanalysis has no parallel. Freud's "depth psychology" would not be considered deep enough by yoga. The repressions of childhood and their uprooting by psychoanalysis may equip a man to meet successfully the problems of life. The method may be sufficient for the goal. But the spiritual objective of yoga, a release from the chain of existence, is attained only by a contrary procedure, the extinction of life-instinct itself. Can there be any two ideals more mutually opposed?

On page 152 we find an objection to Freud which, in the light of most anti-Freudian literature, is wond'rous strange:

> In spite of much speculation that is involved in Freudian thought, one might wonder *how much further it would have gone* if it were not for the restraints of science which are bound to exert a remote control even on psychoanalysis? (Reviewer's italics.)

This, indeed, is something different—an objection that might well be applauded. Elsewhere Dr. Behanan says, "Some thought that Freud would probably turn out to be a 'mystic' and philosopher. But his book, *The Future of An Illusion*, has revealed him as a consistent materialist, and for that matter, a hard-boiled one."

Especially illuminating for the uninformed in these realms of knowledge, who so often think of the yogin as a bearded, emaciated fellow lying composedly upon a bed of nails, is the statement, on page 186, that "in the progressive development of a yogin special attention is paid to the building of a healthy body." The chapters on posture, breathing and concentration exercises give an unusually clear and practical insight into the purposes, both psychical and physical of such practices. The postural and breathing exercises have effective prescriptions to offer in increasing the individual's control over his bodily functions.

Not satisfied with introspection examination of yoga in its psychological implications, the author introduces experimental evidence, and states (page 232): "Those who are inclined to believe that yoga is a beneficial training for mental development may be a little surprised by our conclusion that there is a retardation of mental functions after yogic practices. But we have not even raised, let alone answered, the question as to what effect these practices have on the mind over a long period of time."

Dr. Behanan's opinion of his personal benefits from yogic practices involves "an emotional stability and balance which I do not remember having possessed prior to taking up these exercises . . . I seem relatively able to prevent self-victimization by emotional extremes." Just as a wild guess, would this imply that the surface has been barely scratched in the use of physical training as a therapeutic adjunct in the field of mental hygiene? The supposition is at least worth pondering.

This work is valuable in its awakening of fresh lines of thought as well as in its manifestly objective treatment of a topic so subjectively colored.

Heredity and the Ascent of Man. By C. C. Hurst, Ph.D., Sc.D., New York. The Macmillan Company. Cambridge, England: at the University Press. 138 pages. 1935. Price $1.50.

This little volume is primarily a study in Mendelism as affected by the gene theory. It is a rapid and useful survey of the great mass of material which has been accumulated since T. H. Morgan's investigations into the nature of inheritance in the fruit fly. In view of the limited space, the development is necessarily lacking in detail. The author, however, has written more extensive volumes, to which any interested reader may turn for the more detailed experimental evidence.

The chief interests in the volume appear to be the philosophical interpretations with respect to the bearing of Mendelism upon evolution. Gene mutations are the material upon which discontinuous variation must be based, and upon these variations Darwinian selection is assumed to play its preponderant rôle. In view of the stress placed by the author on the production of gene mutations by environmental measures, such as the application of X-rays, it is rather surprising to see what little importance he attaches to the influence of environment in shaping intellect. The social implications of the hereditary factors lead him to a eugenic interpretation. Though no informed reader will doubt the importance of sound heredity, one will probably feel that the effect of social institutions in molding the mind has not been duly appreciated. However, the book is stimulating and provocative, and will tend to encourage further reading.

The Psychology of Eating. By LEWIS R. WOLBERG, M. D. Robert M. McBride and Company, New York, 1936. 291 pages, bibliography and index. Price $3.00.

Dr. Wolberg has provided the general reader with a diverting conducted tour through the gastronomical jungle. In the early chapters of this book one is greeted by ethnological data which make him pause and wonder at the fastidiousness which modern man displays in matters of food choice and food consumption. Not a little space is devoted to etiquette, its origins and later elaboration. Nearly everything found in these introductory pages is definitely superficial, related for the greater part in the nature of disjointed anecdotes. Farther on, numerous dietary fads are given a sound beating or are ridiculed out of countenance. It is likely that the reader will be somewhat puzzled in scanning the short diatribe on "The Calorie Bubble." To quote the author: "The establishment of the calorie as a respectable household unit led to many disappointments. As a yardstick for the measurement of gross energy changes, it was academically accurate, but as a means of arriving at a proper balanced daily ration, it was positively worthless." After all, scientific investigation of any problem demands a terminology and a means of measurement that will guarantee "academic accuracy." If the general populace is to benefit from the findings of the laboratory, translation into its terms will come later—how could it come before? True enough, the author obligingly furnishes this "language of the kitchen," but his disdain for the calorie (which, however, he carefully includes in his tables of food values) is unwarranted and a bit pointless.

The above, be it admitted, is as far from an evaluation of the book as a whole, as the book is from its title. Of the "psychology of eating" there is precious little. Personality deviations rooted in feeding problems and dietary idiosyncrasies rooted in unconscious conflicts, are left severely out in the cold. Where one might have expected to find new light on the dynamics of food likes and dislikes, one meets with only a museum of gastronomical curiosities. That Dr. Wolberg may achieve the objective of reader interest for the public does not compensate in any sense for the disappointment that will come to the psychiatrist when he vainly searches for a real contribution in so fertile a field of investigation.

Vitamin hunters, vegetarians, flesh eaters, and others of the author's targets, all have been held up to ridicule before; there is no advantage in adding another sting of the lash. Far more could have been accomplished by the assumption of an objective mental hygiene attitude and the penning of good, sound psychiatric advice on the psychic disorders attendant upon

dietary difficulties, rather than by the inconoclastic leer that pervades so many paragraphs of this misnamed volume.

The charts and tables of food values, the menus, the weight charts, it is granted, lend a distinctly practical value to the book. Judgment of their reliability is waived in virtue of the failure of the work to live up to its title. Elsewhere in this issue of the QUARTERLY appears an article which goes beneath the surface of table manners for its psychology of eating.

The Adolescent in the Family—A Study of Personality Development in the Home Environment; Report of the Subcommittee on the Function of Home Activities in the Education of the Child. A Publication of the White House Conference. D. Appleton-Century Company, New York, 1934. 470 pages. Price $3.00.

This report of the subcommittee gives the results of an ambitious study to determine the relations between conditions in the home and the personality and conduct of children. Information was obtained by the questionnaire method from 13,000 public school children and several hundred public school teachers. Rural, village and urban children were studied and comparisons made of white American, negro and immigrant children. The subcommittee summarizes its work in 12 recommendations, including: need for further research; necessity for an institute of family research; establishment of more child guidance clinics in connection with public schools; setting up of family consultation centers; extension of public nurseries and preschool centers for children; better supervision of children in broken homes and homes with the mother employed; encouragement of child study clubs for parents; development of program for instruction of parents in sex education of children; and better organization for prevention of juvenile delinquency.

The cultural contacts of parents are shown interestingly by the study. Here the church and its organizations are outstanding, 39 per cent of the mothers of all classes attending; no other social activity reaches half that percentage. However, more than one-half of poor mothers and about one-third of lower middle class mothers belong to no social or church organization whatsoever. This suggests the church may not be taking full advantage of a great opportunity for constructive social work among the poorer classes constituting more than half of the families studied.

Within the limitations of the questionnaire method, which are serious and numerous, the study throws much light on the home life of the several groups and environments studied; also on the mental processes and reaction of children in such homes and surroundings.

It is to be regretted that work of this sort is too frequently published in so dull and uninteresting a form, that it is at times almost unreadable. Drastic condensation, omission of case histories and an interesting style of presentation would do much to popularize the findings of this subcommittee.

So You're Going to a Psychiatrist! By ELIZABETH I. ADAMSON, M. D. Thomas Y. Crowell Company, New York, 1936. 263 pages. Price $2.50.

Here is a book that should reap a harvest of understanding. Not only is its subject matter skillfully presented, but its rhetorical style is easy-flowing, down-to-earth, and should be comprehensible to the intelligent lay person.

The opening chapter seeks to orient the reader in psychiatric conceptions of some well-recognized personality types, the "good mother," the "benevolent patriarch," and other self-styled martyrs of the home and fireside. From this introduction the author launches upon an exposition of psychiatry, what it is, and the gap that existed in the total treatment of the individual before this discipline became crystallized. A particularly lucid statement appears on page 38: "It (psychiatry) is merely a modernization of a long neglected field of medicine—the emotional life—brought at last within the legitimate scope of modern medicine." There can be no doubt that in the eyes of the many, psychiatry is veiled over with a film of occultism; Dr. Adamson tries to dispel this misapprehension, saying that "in all the subtle fields of emotional disorders, it differs from plain common-sense only as metallurgy differs from blacksmithing—supplementing, elaborating, and formulating, rather than contradicting it."

In a chapter entitled "Polities of the Mind," the reader will find an account of the modern psychiatric interpretation of personality. Theory is supported admirably by fitting illustration. The stress here, as throughout most of the book, is upon the infinite importance of a proper child-parent relationship. Again and again Dr. Adamson shows how parents unwittingly use their offspring as weapons in wreaking vengeance upon their own unfortunate pasts. The Id-Ego-Superego structure is delineated with unexcelled clarity.

Altogether this volume ranks with the best of the presentations of psychiatry for the edification of the lay reader. It merits a prominent position on the shelf of the home library and should be a suggested reading as an adjunct to psychology courses in college. Unfortunately, librarians will doubt its reliability as a reference reading because of its catch-phrase title, but it is to be hoped that they will read the book from cover to cover, whereupon they cannot ignore its inherent value.

Woman's Prime of Life. By ISABEL E. HUTTON, M. D. Emerson Books, Inc., New York. 1937. 150 pages. Price $2.00.

Dr. Hutton has written for the benefit primarily of women a sensible and well-balanced book, which deals with the climacteric period. It might be described as advice on how to live through the middle decades of life wholesomely. One might feel that an author, in singling out this period of a woman's life for discussion, would make the error of emphasizing the disorders which are popularly attributed to that period of life and perhaps do harm by emphasis thereby given to the years between 40 and 50. Dr. Hutton, however, is at some pains to point out the physiological character of the menopause and to insist that it should be passed through without the appearance of distress or illness. She very properly says that much superstition exists with reference to the supposed vulnerability of women to mental and physical disorders of various kinds which appear only at that period of life. She also makes another pointed observation which is in need of dissemination and which pertains to the menstrual function. It is summed up in one short sentence, as follows: "It can safely be said that no healthy girl or young woman should suffer pain (during the menstrual period) if hygienic rules are followed."

She further points out that many of the cases of dysmenorrhea are women whose minds are morbidly fixed upon their organs of generation and who have had the tradition of the "Curse of Eve" handed down to them. After discussing the physiology and disorders associated with the climacteric, she passes on to the consideration of the hygiene and gives some excellent advice which particularly centers about personal hygiene.

Chapter on exercises, on weight reduction and on the art of living complete the small book. It is recommended as wise and sensible.

Children Handicapped by Cerebral Palsy. A description of the psychological factors in management. By ELIZABETH EVANS LORD, Ph.D. The Commonwealth Fund, New York, 1937. 100 pages. Price $1.25.

Dr. Lord's book relates the results of a careful survey of over three hundred cases of cerebral palsy. The book is well divided, reviewing the cases from the physical, psychological, educational and emotional angles. Particularly gratifying to all who are interested in these children is her method of evaluating the mental level, according to clinical psychology, rather than using the hard and fast psychometric tests which are not always applicable to the physically handicapped child.

From the physiotherapists' viewpoint, Dr. Lord's conclusions, concerning the physical improvement which can be expected after the age of six years, are a little on the pessimistic side and open to discussion.

Dr. Lord's comprehensive book can be recommended to all physicians, psychologists, parents, teachers and physiotherapists who are interested in the problems confronting the child handicapped by cerebral palsy.

Crime and Sexual Development. Movement and fixation of the libido in criminotic individuals. By ARTHUR N. FOXE, M. D., Glens Falls, N. Y. (published by the author) 1936. 91 pages. Price $2.75.

Most of the books dealing with criminal behavior take little note of the deep unconscious sources within the individual which prompt him to criminal acts. Some clinic studies have gone into this phase of the subject to some extent, but the reviewer knows of no other writer who approaches his subject in just the manner of Dr. Foxe. His writing evinces familiarity with orthodox psychoanalytic principles and methods. He sees criminal propensities and manifestations as symptoms of interest to the psychiatrist as symptoms are observed and studied in modern mental hospitals, and that is his method of approach.

The psychosexual immaturity, the fixations at various levels of evolution of the instinct are related to the nature of the criminal acts. He has observed an oral-sadistic type with inclinations to wound, injure or kill (incorporation) and an anal type exercising greater caution and having more regard for subsequent penalities. Many other types of aggression has he studied and presented in this stimulating monograph. One wishes that he had elaborated his case reports to do greater justice to his presentation; some are given only a few lines.

In scientific study of morbid social behavior, the terms in common use are weighted with moral values. To escape the hampering of free thought in the consideration of asocial acts he has coined new words. He approves the modern application of the term *delinquency* but it is unsuitable for application to his state prison material. "Criminosis" is suggested. "It at once describes a certain form of behavior in the individual and a social judgment; yet it also permits an objective view." He uses too, the adjective, "criminotic."

Dr. Foxe working alone at Great Meadow Prison and out of continuous contact with medical and psychoanalytic circles has written a monograph which is of great promise. It is to be hoped that as his work continues he will make further contributions to medicine and penology from a field that for a long time has been in need of cultivation.

Freud and Marx. A dialectical study. By REUBEN OSBORN, with an introduction by John Strachey. Equinox Cooperative Press, New York, 1937. 285 pages. Price $2.50.

Just how Freudian principles are to be woven into the scheme of a socialistic state is not made entirely clear in this volume. Nevertheless, the author displays a good working knowledge of psychoanalysis and in many instances achieves striking comparisons between the father of socialism and the founder of the psychoanalytic school. That the two men bear comparison cannot be denied, in view of their being revolutionaries in their respective fields.

Briefly, the author's thesis is this: (page 135) "While psychoanalysis may, in a general sense, be defined as a science dealing with the desires and urges characteristic of man, so, in similar terms, Marxism may be defined as the science dealing with the external conditions which either fulfill or frustrate those desires." The conclusion is reached that while the two disciplines are dialectical opposites their disparities complement one another to complete the pattern of social organization. One who would seek balance in society must not neglect the subjective aspect of human behavior for the more obvious objective phases of social reform. Although this is chiefly intended for an exhortation to Marxists its implications should be felt in other circles.

A skillfully drawn parallel occupies much of the book, in pointing out to the followers of Karl Marx the similarity of the rôles of the superego in the personality, and the state in the social order. No errors in understanding of Freudianism are apparent, the author referring chiefly to the Introductory Lectures on Psychoanalysis; he quotes this work freely, with abundant illustration.

The book is well worth reading for the insight it gives into at least one philosophical phase of psychoanalysis.

Research in Dementia Præcox. NOLAN D. C. LEWIS, M. D. The National Committee for Mental Hygiene, New York, 1936. 320 pages. Price $1.50.

Dr. Lewis was selected by a competent committee to be field representative and coordinator of research in dementia præcox, an investigation founded by the Northern Masonic Jurisdiction of the Scottish Rite. The Supreme Council made available to the National Committee for Mental Hygiene a generous sum to be devoted to research projects in dementia præcox. It is remarkable that the idea of undertaking this research project and the initiative was taken by the Supreme Council itself and was not a grant in re-

sponse to solicitation by the National Committee or by any other organized research group. With rare generosity, the fund was made available without specifications or restrictions but only with the request that it be employed for the purpose indicated.

In presenting this first report, Dr. Lewis is setting the stage for a comprehensive investigation, which presumably will have the continued support of the Supreme Council. The book, therefore, is appropriately not a treatise on dementia præcox. If one opened the book with the expectation of finding it a textbook, his expectations would not be realized. It is a clear statement of the present state of knowledge concerning this protean disorder, an orientation as it were, of studies carried on since the World War and indications of the direction most promising for further observation and research. An extensive bibliography is a part of it.

Dr. Lewis has done the task admirably. The volume will repay the time spent on it by the general reader and will be invaluable to the investigator.

NOTES

—Announcement has been received of the establishment of the Associazione Internazionale della Stampa Medica. This organization will strive for a coordination of the medical press of the world and will offer the especial service of a clearing house for exchange references. The address is 47, Via due Macelli, Rome, Italy.

—At its third institute on the exceptional child, held on October 15, 1936, the child research clinic of the Woods Schools, Langhorne, presented a program of papers under the general title "What Science Offers the Emotionally Unstable Child." The text of the papers, as well as the discussion that followed them, appears in a booklet which may be obtained by communicating with Mrs. Irene S. Seipt, director, Child Research Clinic, The Woods Schools, Langhorne, Pa.

—Dr. Horatio M. Pollock, director of mental hygiene statistics, and Miss Hester B. Crutcher, supervisor of social work of the New York State Department of Mental Hygiene, have been designated to work with Dr. Arthur H. Ruggles, superintendent of Butler Hospital, Providence, R. I., in a projected study of the system of family care of mental patients in Germany. They will go abroad in the summer, at which time Dr. Pollock will also attend the International Congress on Mental Hygiene in Paris, July 19-23, and the International Congress on Population.

—Dr. Harry C. Storrs, superintendent of Wassaic State School since July 1, 1930, will assume the superintendency of Letchworth Village on July 1 of this year. Like his predecessor, the late Dr. Little, Dr. Storrs is a son of New Hampshire and an alumnus of Dartmouth College. From a year of affiliation with the Maine State School for Feebleminded at Pownall, he entered the New York State service as Dr. Little's first assistant at Letchworth Village, a position he held for 18 years and which he relinquished to head the new State school at Wassaic, N. Y.

—The ninety-third annual meeting of the American Psychiatric Association was held in Pittsburgh, May 10 through 14, 1937. An abundant program of papers and discussions bore witness to the increasing and multifarious application in modern medicine of a psychiatric point of view. The following officers were elected: Ross McClure Chapman, M. D., president; Richard H. Hutchings, M. D., president-elect; William C. Sandy, M. D.,

secretary-treasurer. The following fellows were elected concillors for three years: Charles H. Dolloff, M. D., George S. Johnson, M. D., Harry E. Solomon, M. D. Dr. Robert P. Winterode was chosen auditor for three years.

—On the occasion of the twenty-fourth anniversary of the opening of the Henry Phipps Psychiatric Clinic, Baltimore, Md., prominent psychiatrists from all over the country gathered together at a testimonial dinner to honor Dr. Adolf Meyer, April 16, 1937. More than four hundred persons were present at the dinner. Dr. Charles Macfie Campbell presided, and tributes were paid to Dr. Meyer by colleagues in his profession from both the United States and abroad.

—The first semiannual conference of the stewards of the institutions in the New York State Department of Mental Hygiene was held at the Brooklyn State Hospital on February 11, 1937. Mr. John R. Heilman, steward of the hospital, presided as chairman. After an address of welcome by Dr. Clarence H. Bellinger, papers were read by Mr. Jesse A. Cotter, steward of Pilgrim State Hospital, and by Mr. Leo J. Frey, steward of Central Islip State Hospital. Spirited and fruitful discussion followed the reading of these papers. This was the first meeting of its kind in the department; another such meeting is planned for the fall of this year.